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ABSTRACT

Designed for teachers of the severely handicapped within the Arizona public schools, the manual reviews current practices in special education for this population. An initial chapter examines student characteristics, while a second reviews current practices in assessment (including brief descriptions of vocational, social, perceptual, language, intelligence, and adaptive behavior tests). The following topics are explored in separate chapters (sample subtopics in parentheses): staffing and related services (roles of therapists, social workers, psychologists, etc.); individualized education plan (required components); curricular options (brief descriptions of 24 approaches, procedures for modifying and developing curricula); teaching strategies (15 guidelines); relationship to regular education (critical factors); learning environment space design (physical design and materials/equipment); and linkages with the residential setting (teacher-parent programing, parent counseling, parent to parent group). Chapters frequently conclude with sample forms and a list of references. Seven appendixes address such special concerns as medical factors, feeding, and transportation. (CL)

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CURRENT PRACTICES FOR SERVING
THE SEVERELY HANDICAPPED IN PUBLIC SCHOOLS

A Resource Manual for Teachers

June, 1979

Developed for

The Division of Special Education
Arizona Department of Education

by

The Southwest Regional Resource Center
Department of Special Education
University of Utah
H. Wayne Johnson, Director

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Bureau of Education for the Handicapped
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INTRODUCTION

History of the Problem

Deinstitutionalization of the mentally retarded and the profoundly handicapped represents one strand of a recent complex consciousness of civil rights of individuals in the United States. While the process of deinstitutionalization has been underway in various locales for several years, the success of the transfer of handicapped persons from institutions to what should be more normal, less restrictive environments has been mixed, depending on how well services in the community have been planned, coordinated, and maintained. Success or lack of success has also been determined by the preparation of residents of institutions for their move to the community.

The Education for All Handicapped Children Act (Public Law 94-142) strengthens the concept of equal opportunity for all school-aged persons; coupled with the deinstitutionalization movement, new types of educational services are mandated for a population of persons who heretofore have been mainly excluded from public school services.

At the moment, students who will be entering the schools for the first time will come from four living situations: some will still live at the institution, but attend the public schools; some will come to school from foster homes; others will come from state-operated group homes; some will come from their natural homes. Because PL 94-142 mandates the active participation of the parents in the educational program of a handicapped child, the identification of authority to serve as guardian, foster parent or surrogate for the child is a priority.

Arizona is now beginning the third of a five-year plan to move the individuals in the Arizona Training Programs and in the Arizona State Hospital into communities--and those of school age, into public schools. It is hoped that this resource manual will smooth the transition for schools taking the first steps toward serving the severely mentally retarded and other profoundly handicapped persons from the institutions and communities. On the other hand, this document recognizes the appropriate educational services that have been provided for some time in many of Arizona's public schools for children who have complex and profound mental and/or physical disabilities.

How to Use This Manual

This Resource Manual is designed especially for teachers of the severely handicapped within the public schools. The document represents a summary of some of the current practices of public school personnel in the United States, but the information is by no means exhaustive of all the subject matter. An intentional effort has been made to pinpoint information of an exemplary nature in a crisp and succinct fashion.

A common format was used for all chapters of the manual, with each containing four parts: introduction, current practices, bibliography, and sample forms. The introduction sets the stage for each chapter by giving the reader a context or rationale for the subject covered. The current practices part addresses key components and considerations to facilitate the teacher in developing a comprehensive program. The bibliography is a selection of some of the major resources which could be used to suggest additional research, preparation, or implementation. The forms at the conclusion of each chapter give the teacher some methods which might be useful in implementing various aspects of a student's program. These forms are samples and do not represent official state or district policies. The Appendices represent some special concerns (medical, transportation, etc.) and act as an overlay of information on the more programmatic issues covered in the chapters.

The Southwest Regional Resource Center takes special pleasure in joining with the Arizona State Department of Special Education in the preparation of this manual, which is unique and comprehensive in its attempt to address the subject of implementing programs for the severely handicapped within the environment of the public schools. It is hoped that this product will be a valuable inservice support to teachers of the severely handicapped who are striving to effect best practices in their classrooms.

June 1979

Table of Contents

Section

One: Characteristics of the Severely and Profoundly Handicapped Child

Two: Assessment

Three: Staffing and Related Services

Four: Individualized Education Plan

Five: Curricular Options

Six: Teaching Strategies

Seven: Relationship to Regular Education

Eight: Learning Environment Space Design

Nine: Linkages with the Residential Setting

Appendix

A: Special Concerns: Medical

B: Special Concerns: Emergency Resources

C: Special Concerns: Feeding

D: Special Concerns: Toilet Training

E: Special Concerns: Transportation

F: Teacher Aide Training

G: Self-Evaluation Checklist

SECTION ONE

CHARACTERISTICS OF THE SEVERELY AND PROFOUNDLY HANDICAPPED CHILD

Severely and profoundly handicapped children and youth are, first of all, individuals with needs, secondarily, handicapped individuals with special needs. Their developmental characteristics can be described only after normal developmental characteristics are known. The main discrepancy between developmental patterns of retarded and nonretarded children is the time intervals between developmental steps, i.e., the progression is usually much slower. Retarded children have many and/or severe deficits and require a well-planned curriculum in all areas of functioning.

After many years of debate about heredity vs. environment, most people would agree that both are important, both influence the child's development, both impose themselves upon the child's potential. Many factors are genetically or prenatally determined, but the influence of the environment is powerful and the development of the child's potential depends on all of the environmental forces: nutrition, stimulation, love, training, health care--the nurturing of the child. Even the child with the most impressive of deficits can be greatly influenced by the richest nurturing.

Early development and the nurturing thereof are critical building materials for later accomplishments; each growth step is a function of the quality of the preceding one. Therefore, the highest quality nurturing at each point on the developmental continuum is of critical importance. Research suggests that, conversely, failure to nurture at any given point, from the earliest days of infancy, not only inhibits proper development, but can even prove destructive in that particular developmental area, and in others as well.

Much of a normal child's development takes place more or less automatically and in a relatively smooth way. The severely handicapped child does not acquire learning and experience with the same facility; the acquisition of skills requires careful planning and training. This planning and training must be based on a carefully and minutely described developmental continuum. Thorough and comprehensive knowledge of developmental progressions is a critical factor, an essential area of expertise for the professional involved in the education of the severely handicapped.

In summary, the study of developmental stages is essential for three reasons:

1. Skill building is cumulative; development of each skill depends on the acquisition of smaller, simpler skills.

2. Various areas of development tend to be at the same level and to be interrelated.

3. Developmental progress cannot be taken for granted in the severely and profoundly handicapped child and must be carefully provided for.

For the teacher of severely and profoundly handicapped students, identifying the characteristics of this type of child involves a multifaceted approach. Due to the mental, emotional, and physical involvements, it is recommended that various procedures be considered. The identification of characteristics should include both strengths and weaknesses.

The information that follows is provided to alert the teacher to characteristics that should be considered in serving the severely, profoundly handicapped child. This information is not a formal assessment or diagnostic inventory, but a listing of characteristics that should be helpful in: (1) allowing the teacher to observe the student's behaviors to determine if adequate diagnostic information is available; (2) assisting the teacher in requesting additional student information based on what is available and on observed characteristics; (3) providing a basis for program planning:

A. Behavioral Characteristics
    1. Inconsistent
    2. Overreacting
    3. Withdrawn
    4. Dependent
    5. Repetitious
    6. Aggressive
    7. Unresponsive
    8. Nontransferable
    9. Rigid
    10. Lacking attention control

B. Motor Characteristics
    1. Primitive movements
    2. Developmental lag
    3. Astasia
    4. Rigid
    5. Equilibrium reactions
    6. Righting reactions
    7. Clumsy
    8. Balance reactions
    9. Positions in space
    10. Agility
    11. Eye-limb
    12. Coordination lag (gross; fine; eye/hand)

C. Cognitive Characteristics
  1. Association
  2. Classification
  3. Categorizing
  4. Inductive
  5. Deductive
  6. Analyzing
  7. Interpretive
  8. Critical
  9. Creative
  10. Memory
  11. Generalization

D. Communication Characteristics
  1. Prearticulation
  2. Articulation
  3. Expressive
  4. Receptive
  5. Semantical
  6. Syntax
  7. Figurative
  8. Relation to behaviors
  9. Nonverbal

E. Social Characteristics
  1. Interpersonal relationships
  2. Reactions
  3. Timing
  4. Transferring
  5. Independence
  6. Social structure (e.g., taking turns)
  7. Environmental interaction
  8. Crisis reactions
  9. Verbalizing
  10. Nonverbal
  11. Responsible
  12. Social speech

In summary, the process of profiling characteristics of severely and profoundly handicapped children, leading to more effective teaching and learning, moves from a gross interindividual characteristic to a very precise analysis of each child's idiosyncratic character for learning. The steps and stages of profiling characteristics could be summarized as:

1. Interindividual analysis based on controlled characteristics with the objective of ascertaining the child's predicted level of ability.

2. Characteristic identification to detect strengths and weaknesses within potential capabilities.

3. Determinations of difficulties within specific learning tasks where the child displays weaknesses.

4. Survey of the strategies the child uses as he/she interacts with a task and discovery of those areas of communication by which learning ultimately occurs.

Because the needs of the severely or profoundly handicapped student are complex and multifaceted, the child's school records should verify that needed assessments, based on strengths and weaknesses, have been completed, and that information relevant to the diagnosis and prescriptions for the remediation of problems comes from several sources:

Child's School Records:

A. Assessment information
B. Medical records
C. Anecdotal information
D. Adaptive behavior information
E. Parent information
F. Observations
G. History
H. Outside agency data
I. Developmental growth based on normal patterns

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SAMPLE

SAMPLE WORKSHEET FOR IMPLEMENTATION

Instructions: The three columns at the right can be labelled with student names. A suggested coding of characteristics could be as follows: A = always, F = frequent, S = seldom, N = never.

Student Names:			
A. Behavior Characteristics			
1. Inconsistent			
2. Overreacting			
3. Withdrawn			
4. Dependent			
5. Repetitious			
6. Aggressive			
7. Unresponsive			
8. Nontransferring			
9. Mechanical			
10. Rigid			
11. Attention control lack			
B. Motor Characteristics			
1. Primitive movements			
2. Developmental lag			
3. Astasia			
4. Rigid			
5. Equilibrium reactions			
6. Righting reactions			
7. Clumsy			
8. Balance reactions			
9. Positions in space			
10. Agility			
11. Eye-limb			
12. Coordination lag (gross; fine; eye/hand)			
C. Cognitive Characteristics			
1. Association			
2. Classification			
3. Categorizing			
4. Inductive			
5. Deductive			
6. Analyzing			
7. Interpretive			
8. Critical			
9. Creativity			
10. Memory			
11. Generalization			

SAMPLE
(Cont'd)

Student Names:			
D. Communication Characteristics			
1. Prearticulation			
2. Articulation			
3. Expressive			
4. Receptive			
5. Semantical			
6. Syntax			
7. Figurative			
8. Relation to behaviors			
9. Nonverbal			
E. Social Characteristics			
1. Interpersonal relationships			
2. Reactions			
3. Timing			
4. Transferring			
5. Independence			
6. Social structure (taking turns)			
7. Environmental interaction			
8. Crisis reactions			
9. Verbalizing			
10. Nonverbal			
11. Responsible			
12. Social speech			

SECTION TWO

ASSESSMENT

Underlying an appropriate program for a handicapped student is an appropriate assessment. Care must be taken that the educational evaluation or assessment instruments are unbiased for all children; additional precautions must be taken when the child to be evaluated is also severely impaired.

Children who come into the public schools from an institution will bring with them many types of records. It is the responsibility of the school to determine if the evaluations are current and if they provide the kinds of information needed to develop a meaningful program. If the evaluations are not adequate, perhaps other records are still at the institution, and could easily be obtained. If not, the school should arrange to have additional testing performed to assure that an appropriate program will be developed for each student.

The assessment of handicapped children and youth demands that a trained and properly certified practitioner administer and interpret the results of most of the tests. The information that follows has been compiled to present an overview for the teacher of the types of information that can be obtained from various tests.[1]

The purpose of assessment of a handicapped student is to provide prescriptions for his/her education. It is important to assess the individual child's specific skill levels in a number of areas so that the child's program can be structured to meet the specific needs identified. These areas include ability levels, achievement, adaptive behavior, sensory acuity and perception, speech development, motor skill levels, personality, and vocational development.

Some formal assessment instruments which are acceptable for normal children are not appropriate for severely involved children when used in a standardized manner. However, many of these tests can provide considerable information about a handicapped child if they are adapted to meet the child's specific needs. The child should be screened initially to determine the nature of the involvement. Tests can then be selected which will assess specific skill levels including strengths and weaknesses. For example, a typical intelligence test may not be appropriate for a child, but one or two of the subtests may provide information which will be valuable in developing the educational program. If only a subtest is administered, the psychologist's report should note that the entire test was not given, and state the manner in which the administration was adapted.

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[1] The information in Parts 1 and 2 is primarily from Administrators Resource Manual for the Deinstitutionalization of Children and Youth. Prepared for the Division of Special Education, Arizona Department of Education, by the Southwest Regional Resource Center, January, 1979.

Many handicapped students have untapped skills. They may be able to perform at a high level on specific tasks if the proper assessment tool is used. Often observations or developmental scales are most helpful. It may also be necessary to test for process deficits. Children may also be physically uncoordinated due to lack of experience rather than due to a physical handicap. All areas should be examined if the child's needs are to be met. Severely handicapped children are not significantly different from other students in many areas, and it should not be assumed that they cannot be tested (communication difficulties, however, sometimes complicate the measurement of certain characteristics).

Criterion-referenced tests are most useful for providing the type of information required for programming. It should be noted that standardized tests can be used in this same manner. The important information to obtain is whether or not a child has developed a specific skill necessary for further training.

The administration of any test should provide valuable information regarding problem-solving style, ability to follow directions, and the like which could be used in programming. Often tests which are used for normal students can provide considerable information about handicapped students. Informal testing techniques or observations are additional methods of gathering information about a child's functioning level. It is important to determine where the child fits into the ongoing educational process. Any testing techniques which can determine the child's skill levels will be effective in helping develop an appropriate program.

With the severely handicapped population it is important to utilize a multidisciplinary approach to assessment, i.e., educational, psychological, social, medical, etc. The following are intended to suggest some of the types of tests that can be used to assess these students:

ADAPTIVE BEHAVIOR TESTS

The most useful devices for assessing the functional level of handicapped students may be the infant development scales and the adaptive behavior scales. These are useful in planning specific programming and are helpful in evaluating many different areas of developmental functioning. Such areas include motor development, perceptual development, social skills, language, self-care, and general levels of ability. Some districts in Arizona have also developed effective adaptive behavior scales which can be obtained upon request.

Test	Description
AAMD Adaptive Behavior Scale	This scale provides a measuring device for assessment of the mentally handicapped, emotionally maladjusted, or developmentally impaired individual. It can be administered to children or adults and indicates the individual's coping ability and maladaptive behavior.
Bayley Infant Scales	This is a carefully standardized, well-planned, and comprehensive measure of infant development. It provides scores on mental and motor development plus behavioral ratings. It can be used to measure the developmental levels of severely impaired children.
The Bayley Scales of Infant Development: Modifications for Youngsters with Handicapped Conditions	This tool is designed to assess cognitive development in handicapped babies, two to thirty months, by circumventing the effects of their physical limitations. The standard Bayley is first administered and then a second score is achieved by modifying the standard procedures.

Test	Description
Gesell Developmental Schedules	These instruments test mental growth through quantitative measurements of language, motor development, adaptive behavior and social behavior.
Vineland Social Maturity Scale	This scale provides information about the social development of the individual. There is some indication that these scores are related to mental age and intelligence in younger children. It is administered by interviewing someone familiar with the child, so it can be used with children who are very difficult to test. Norms should be adapted when testing hard-of-hearing children, which may be necessary for other severely handicapped children as well. The test is easy to administer and inexpensive.

INTELLIGENCE TESTS

Standard intelligence tests can be used with handicapped children but may require adaptation. Some children have handicaps which have not affected intelligence and, for them, the standardized tests may be appropriate.

Test	Description
Columbia Mental Maturity Scale	This test was designed to measure the intelligence of handicapped children. It is a nonverbal test with minimum motor responses required. It has been used with deaf children and has been found to be beneficial as an intelligence measure. Care should be used in interpreting results as they may be somewhat misleading.
Progressive Matrices (Raven)	This nonverbal test may be used with the mentally retarded, deaf, and language impaired. It measures innate educative ability through a single modality of performance and is good as a second test to substantiate another more comprehensive intelligence test.

Test	Description
Progressive Matrices (Raven) - cont'd.	The test is easy to administer and score and is inexpensive. It may yield invalid scores of impulsive children who tend to respond randomly rather than with accuracy and care. The examiner should observe the child carefully to assure that he/she is really trying.
Stanford-Binet Intelligence Test	This test must be administered by a trained diagnostician. It yields a global intelligence quotient. Individual subtests may be particularly useful in identifying program needs of handicapped children.
Wechsler Adult Intelligence Scale (WAIS)	This intelligence scale provides three scores: full-scale intelligence, performance intelligence, and verbal intelligence. Twelve subtests are available with scaled scores. Individual sections or subtests may be appropriate for handicapped children. The test must be given by a qualified diagnostician.
Wechsler Intelligence Scale for Children-Revised (WISC-R)	This test provides the same type of scores as the WAIS.
Wechsler Preschool and Primary Scale of Intelligence (WPPSI)	This has the same format as the WAIS and the WISC-R. Again, specific subtests should be selected for use with an atypical child.

LANGUAGE TESTS

Many severely handicapped children have difficulty with language. It is important to be able to identify problem areas and help the children establish communication.

Test	Description
Northwestern Syntax Screening Test	This is intended as a screening instrument only. It assesses the ability of children 3 to

Test	Description
Northwestern Syntax Screening Test - cont'd.	8 years old in comprehension and formation of basic sentence structure. It assesses both receptive and expressive language skills. Test scores are compared against a norm population.
Utah Test of Language Development	This is a standardized assessment device which establishes a general score relating to the language development of the individual. It provides a language age in receptive and expressive language functioning. The test may not be adequately sensitive for severe levels of mental impairment.

SOCIAL MATURITY TESTS

Many tests which are normally used to assess an individual's personality style and emotional maturity may not be appropriate for children who have been institutionalized. The poor performance of such children may be due to lack of experience rather than to any severe emotional problems. Often the adaptive behavior scales or simple sentence completion tests will be most useful. Care should be taken in comparing these children to a population of children with normal experiential backgrounds. (Note that adaptive behavior checklists are reviewed in a previous section.)

Test	Description
Cain-Levine Social Competency Scale	This scale is devised to rate the social competence of trainable, mentally handicapped children. Scales include self-help skills, social skills, initiative (self-direction), and communication. The scale is standardized on a retarded population and is administered by interviewing.
Draw-A-Person	This is a good screening device for detecting severe emotional problems. It is relatively nonverbal and is probably the most practical projective personality test for handicapped children. Its interpretation is subjective and it should be used only by a trained psychologist.

Test	Description
Rotter Incomplete Sentence Blank	This test is useful with subjects who understand its sophisticated vocabulary, which is sometimes simplified by an experienced examiner. It is probably not useful for nonverbal children.
Thematic Apperception Test (TAT) or Children's Apperception Test (CAT)	This test may be used effectively if the child and the psychologist are able to communicate effectively and if the child has had an adequate experiential background.

PERCEPTUAL FUNCTIONING TESTS

Many severely handicapped children exhibit perceptual problems. In planning programs for these students it may be helpful to be able to identify their particular style of learning in order to provide remediation and compensation for such deficits.

Test	Description
Auditory Discrimination Test (Wepman)	This test is most often used as a screening test of children's auditory discrimination abilities. It can be administered easily by any qualified professional. The test can be administered to speech impaired or cerebral palsied children.
Bender Visual Motor Gestalt Test	This test can provide information about the functional age of some children in regard to perceptual motor abilities. It is easily administered and scored. The test can be used as a personality assessment but requires sophistication in interpretation for such a purpose. It is recommended for children from 4 to 10 years old but can be used for older handicapped children.
Illinois Test of Psycholinguistic Abilities (ITPA)	This test provides information on twelve areas of process skills: auditory association, verbal expression, grammatic closure, auditory reception,

Test	Description
Illinois Test of Psycholinguistic Abilities (ITPA) - cont'd.	visual reception, visual sequential memory, auditory sequential memory, visual association, visual closure, manual expression, auditory closure, and sound blending. It is fairly complicated to administer and requires special training. The test was designed to measure the psycholinguistic abilities and disabilities of moderately and mildly handicapped children.
Marianne Frostig Developmental Test of Visual Perception	This test measures five operationally defined perceptual skills: eye-motor coordination, figure ground, constancy of shape, position in space, and spatial relationships.
Purdue Perceptual-Motor Survey	This test evaluates balance and posture, body image and differentiation, perceptual-motor match, ocular control, and form perception. It yields 22 scores.

VOCATIONAL TESTS

Several types of tests can be included under vocational testing because all the skills measured are thought to have an impact on the training given to a handicapped student in preparing him/her to learn vocational skills. Such tests include those of motor functioning, interests, and specific vocational skills. Elaborate assessment systems that properly assess vocational interests and aptitudes are available through vocational rehabilitation agencies.

Test	Description
Minnesota Rate of Manipulation Test	This test measures the perceptual abilities necessary to match relative shapes and sizes. It consists of moving blocks from the table into their proper spaces in a form with as much speed as possible. The test provides norms for junior and senior high boys and girls and adults. It also includes special instructions for administering the test to the blind.

Test	Description
Pennsylvania Bi-Manual Work Sample	This instrument tests motor skills by combining the basic elements of a relatively simple work situation.

PLURALISTIC ASSESSMENT

SOMPA (System of Multicultural Pluralistic Assessment)	This test utilizes three models (medical, social and pluralistic) simultaneously to assess the child as a human being of several dimensions. It is useful for the child from an ethnic or racial minority, or the child who is economically disadvantaged or socially isolated.

INFORMAL ASSESSMENT AND OBSERVATIONS

In addition to formal testing instruments, many informal assessment and observation instruments can be used by the teacher. Because of the complexity of severely handicapped students' disabilities, no single device should be used to determine a child's program.

A list of test publishers is available in the Administrators Resource Manual for the Deinstitutionalization of Children and Youth, Southwest Regional Resource Center, Salt Lake City, Utah, January, 1979, pp. 44-51. All schools in Arizona should have a copy. It will also be available from ERIC.

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Information on assessment services in Arizona may be obtained by contacting: CHILD FIND (800) 352-5468, Maricopa County 255-5200 or local school districts.

SAMPLE

STUDENT RECORDS

Each school system is required to obtain and maintain records on each exceptional student served and report annually to the Department of Education, Division of Special Education, as requested. Each school system shall maintain complete, confidential records on all exceptional students. Such records shall include:

School District____________________ School________________________

Student__________________________ Parents_______________________

Address__________________________ Telephone_____________________

Birthdate_________________________

Information	Yes	No	Comments
Initial Referral Received			
Observation			
Review of Records:			
Educational History			
Social History			
Language Dominance			
Medical History			
Physical			
Hearing			
Vision			
Parent Permission to Evaluate			
Parent Permission to Obtain Other Info.			
Student Evaluation:			
Individual Intelligence			
Diagnostic Language Assessment			
Individual Achievement Scores			
Adaptive or Behavior Scores			
Perceptual Tests (Learning Disabled)			
Speech Eval. (Speech Impaired)			
Ophthalmological Report (Vision Impaired)			
Otolaryngologist Report, Audiologist Report (Hearing Impaired)			
Appropriate Tests (Behavioral Disord.)			
Physician Report (Physically Impaired)			
Physical Therapist Report			
Occupational Therapist Report			
Other Evaluations			
Committee Recommendations			
Individualized Educational Program			
Parent Permission for Placement			
Minimum Annual Review:			
First Year Review of Placement and IEP			
Second Year Review of Placement and IEP			
Third Year Review of Placement and IEP			

SAMPLE

CRITERIA FOR JUDGING CHILD EVALUATIONS

For each of the evaluations listed as "needed" on the Child Evaluation Checklist, check the following items. Each criterion should be met to the Committee's satisfaction.

Child: ______________________________

Type of Evaluation: ______________________________

Date of Evaluation: ______________________________

Evaluator: ______________________________

____ Report is written in understandable language.

____ Tools or processes used in evaluation are identified.

____ Setting in which evaluation occurred is described.

____ Evaluation contains concise statements of specific results.

____ Identification of problem areas identified by evaluation.

____ Identification of problem areas identified by behavioral observations.

____ Evaluation contains concise statements of strengths and weaknesses.

____ Information is relevant to educational planning.

____ Information describes conditions which influence ability to perform tasks.

SAMPLE

TEST SUMMARY SHEET

Student________________________________

PSYCHOLOGICAL EVALUATION			EDUCATIONAL FUNCTIONING			ADAPTIVE BEHAVIOR			PSYCHOMOTOR-LINGUISTIC			MEDICAL		
DATE	TESTS	RESULTS	DATE	TESTS	RESULTS	DATE	TESTS	RESULTS	DATE	TESTS	RESULTS	DATE	TESTS	RESULTS

SAMPLE

DRAFT LETTER

from the

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
DIVISION OF DEVELOPMENTAL DISABILITIES/MENTAL RETARDATION
1400 WEST WASHINGTON, PHOENIX, ARIZONA 85006

CONSENT FOR SCHOOL ACTIVITY
SPECIAL EDUCATION SERVICES

I hereby authorize and delegate to the DES-DD/MR (____________________)
Unit
authority to sign consents on my behalf for the following public school activities for ______________________________________.
Name of Child

*____ Consent for Evaluation

____ Consent for Placement in Special Education Program

____ DD/MR shall represent me at the IEP meeting

____ Review of and Continuation of Placement

____ Field Trips off Grounds

____ Release of Information

____ Other (specify) ______________

____ Permission to Terminate Placement

Date __________________

____
(Responsible Person)

*Instructions

Parents are to check off the items they are willing to delegate to DD/MR. If an item is not checked, the parents need to be contacted by the school for those items.

SAMPLE

SCHOOL OBSERVATION FORM

(Developed by Central Arizona Child Evaluation Center)

Date Sent: ______________________________
Date Received: ______________________________
Date: ______________________________ Birthdate: ______________________________

____
Name: (Last) (First) (Middle)

Address: ______________________ Phone #: ____________ City ________ State ________

School: ______________________ Director's Signature ______________________
Teacher's Signature ______________________
School Address: ______________________________ Date: ______________________

SCHOOL HISTORY:

Date entered your school ______________________________
Previous school attended ______________________________
Attendance (this year): Days Absent ______________________
Number of days per week in class ______________
Number of hours per day ______________________

PHYSICAL DATA:

Describe any difficulties in:
Hearing: ____

Vision: ______________ ______________________________________

Motor Control: ____
____
____

Does the child receive any special therapies (physical therapy, speech therapy, etc?) ____

If yes, where and how often? ____

General Health and Physical Appearance: ______________________________
____
____
____

Please circle the response to each question which best describes this child.

SOCIALIZATION:

In terms of relating to other children, is this child's play best characterized as:

1. Isolate?
2. Parallel?
3. Cooperative, interactive?

CACEC 11-b
3/9/77

How long is the child able to occupy himself appropriately with toys or instructional materials?
1. Not at all--needs constant adult supervision and direction
2. 5 minutes approximately
3. 10 minutes approximately
4. 15 minutes approximately
5. 15 to 30 minutes approximately

Does the child participate in teacher-directed group activities such as story-time or music without being disruptive?
1. Yes 2. No

Please give an example or two of the type of toys or play activities the child seems to enjoy most:

____________________ ____________________ ____________________

Is there an anything about this child's social development which is of particular concern? 1. Yes 2. No

What type of behavior causes your concern?
1. Overly aggressive
2. Excessively dependent on adult attention and care
3. Usually shy and/or withdrawn
4. Seems unaware of others in the environment
5. Actively avoids interaction with adults and/or children
6. Other: specify ______________________________

LANGUAGE:

Is the child able to follow simple one-step directions?
1. Yes 2. No

Do you consider the child's understanding of language to be:
1. Appropriate for age
2. Poor for age
3. Minimal or nonexistent

Which of the following best characterizes the child's verbal language?
1. No vocalization
2. Babbling
3. Complex jargon
4. Single words
5. Two and three word combinations
6. Sentences

If the child talks, is his speech
1. Usually clear, easily understood
2. Usually understandable to someone familiar with him
3. Very difficult to understand

If the child does not talk, does he have a gesture language for communication?
1. Yes 2. No

MOTOR SKILLS:

Can the child

1.	Sit unsupported?	Yes	No
2.	Walk independently?	Yes	No
3.	Walk up and down stairs?	Yes	No
4.	Jump from a low step or box without falling?	Yes	No
5.	Hop on one foot?	Yes	No

SAMPLE
(cont'd)

Does the child
1. Scribble or draw with pencil crayon? Yes No
2. Hold pencil or crayon with an adult grasp? Yes No
3. Cut with scissors? Yes No
4. Do fine manipulative activities such as placing small pegs in a pegboard, stringing beads? Yes No

READINESS:

Can the child copy a
1. Vertical line
2. Horizontal line
3. Cross
4. Circle
5. Square
6. Triangle

Has he established hand dominance? Yes No
Please circle: left right

Can he name body parts? Yes No
Can he point to body parts on command? Yes No

Can the child give you "just one" of something when asked? Yes No
give you "two"? Yes No
give you "three"? Yes No

Does the child identify his own name when printed on paper? Yes No

Can the child sort objects by
1. Color? Yes No
2. Shape? Yes No
3. Size? Yes No
4. Function? Yes No

Is the child interested in looking at books? Yes No
Does he name the pictures? Yes No
Does he name or talk about the actions in pictures? Yes No

Does the child demonstrate simple one-to-one correspondence (e.g., put a cookie on each napkin?) Yes No

Does the child listen attentively to a short story? Yes No
Is the child able to answer simple questions about the story, e.g., what is the boy doing? Yes No

Does the child show interest in printed words by asking what a sign or poster says or perhaps by asking what you are writing? Yes No
Does the child "pretend" or write, that is, does he make marks with crayons, chalk, or pencil which he identifies verbally as words? Yes No

Have you seen any evidence of significant perceptual problems in this child?
Yes No

ADDITIONAL COMMENTS:

SAMPLE

PARENT QUESTIONNAIRE
(Developed by Central Arizona Child Evaluation Center)

I. MEDICAL

DID YOUR CHILD RECEIVE THE FOLLOWING IMMUNIZATIONS (BABY SHOTS):

DPT (triple shot) No___Yes___Date or Age_____
Polio Vaccine
  shots (Salk) No___Yes___Date or Age_____
  mouth (Sabin) No___Yes___Date or Age_____
Measles Vaccine No___Yes___Date or Age_____
German Measles No___Yes___Date or Age_____
Mumps Vaccine No___Yes___Date or Age_____
Tuberculin Test No___Yes___Date or Age_____
Small Pox No___Yes___Date or Age_____

Was he/she sick after any of these shots? No___Yes___

II. FEEDING AND NUTRITION

Does child require tube feeding? Yes___No___

Was child breast fed? Yes___No___

Does child drink from a bottle or a cup? Bottle___Cup___

If weaned from bottle and breast, at what age? ___________

Does child hold his own cup to drink? Yes___No___

What texture of food does child eat most often?
___Babyfood
___Junior food
___Chopped table
___Regular table
___Finger food (crackers, cookies)

When you feed this child with a spoon:

a. does child close his/her lips to empty spoon? Yes___No___
b. do you scrape the spoon off the child's upper lip to empty spoon? Yes___No___
c. does child consistently push food out of his/her mouth with his/her tongue? Yes___No___
d. does child bite down on spoon and have difficulty letting go? Yes___No___
e. does child choke or gag on food frequently? Yes___No___
f. does child choke or gag on liquids frequently? Yes___No___

Approximately how long does an average feeding take? ___________

Approximately how much solid food does the child eat in an average feeding?
___ tablespoons
___ cupfuls

Approximately how much liquid does child drink in an average meal?
___ bottles
___ ounces
___ cupfuls

Approximately how much milk does the child drink in an average meal?
___ bottles
___ ounces
___ cupfuls

Did you or do you enlarge the nipple hole in your child's bottle? Yes___No___

Did you feed child baby cereal or strained foods through an enlarged nipple hole from a bottle? Yes___No___

Does child swallow food whole that should be chewed? Yes___No___

How many meals does your child eat each day? ___________

Does this child regularly eat between meals? Yes___No___

Does child constantly have his tongue out of his mouth? Yes___No___

Does child drool? Now___Past___ Never___

Who does most of the family grocery shopping? ___________

Who prepares family meals most often? ___________

In what positions does child eat his/her meals?
  lying on his/her back? Yes___No___
  leaning back in your arms? Yes___No___
  reclined in infant seat? Yes___No___
  supported or strapped in high chair? Yes___No___
  sitting erect in high chair? Yes___No___

II. FEEDING AND NUTRITION (cont.)

In what positions does child eat his/her meals? (cont.)

sitting on booster seat at table? Yes___No___

sitting in adult chair at table? Yes___No___

sitting in especially designed or adapted chair? Yes___No___

Describe the above ______________________

____

____

CHECK WHICH OF THE FOLLOWING FOODS THE CHILD EATS AT LEAST ONCE A DAY:

fruits _____
vegetables _____
 green _____
 yellow _____
 leafy _____
meat _____
cheese _____
eggs _____
cereal _____
bread, cookies _____
 crackers _____
 tortillas _____
beans _____
candy _____

fruit juice _____
milk _____
kool aid _____
jello water _____
tea or coffee _____
soda pop _____
peanut butter _____
others __________
____
____
____
____
____
____

III. MOTOR DEVELOPMENT

Does child's body or any body part feel stiffer than you think it should? Yes___No___

Does child's body or any body part feel weaker or floppier than you think it should? Yes___No___

Does child change from feeling stiff sometimes to floppy other times? Yes___No___

Does child seem double jointed? Yes___No___

CHECK YES IF CHILD CAN DO THE FOLLOWING THINGS AND NOTE THE APPROXIMATE AGE AT WHICH HE/SHE BEGAN DOING IT:

Holds head erect and steady when you hold him/her? Yes___No___Age___

Holds head up when lying on stomach? Yes___No___Age___

Sits without outside support? Yes___No___Age___

Moves about on floor on stomach? Yes___No___Age___

Rolls from stomach to back? Yes___No___Age___

Rolls from back to stomach? Yes___No___Age___

Crawls on hands and knees? Yes___No___Age___

Gets self into sitting position? Yes___No___Age___

Pulls self to standing holding onto furniture? Yes___No___Age___

Takes steps without holding on? Yes___No___Age___

Walks steadily? Yes___No___Age___

Runs? Yes___No___Age___

IV. SENSORY DEVELOPMENT

CHECK WHETHER YOUR CHILD DOES THE FOLLOWING THINGS NOW, DID IN THE PAST, OR NEVER DID:

Repeatedly lifts head, arms and legs off floor and "rocks on tummy" Now___Past___Never___

Assists you when pulling him up to sitting by bringing his/her head forward and bending arms Now___Past___Never___

Brings hands and feet together and plays with them on his/her back Now___Past___Never___

Rocks repeatedly back and forth on hands and knees Now___Past___Never___

Rolls over and over to get to places Now___Past___Never___

Enjoys playing in rough and tumble ways with other children and adults Now___Past___Never___

IV. SENSORY DEVELOPMENT (cont.)

Protects self with arms when falling Now___Past___Never___

Uses both arms and legs well together Now___Past___Never___

Takes everything to his/her mouth as a means of exploring Now___Past___Never___

Plays with his own body parts (e.g., tummy, toes, genitals, etc.) Now___Past___Never___

Spends time repeatedly exploring objects in his/her environment (e.g., push pull, close open, poke with finger, rub, etc.) Now___Past___Never___

Cries when falls and hurts self Now___Past___Never___

Walks stiffly or awkardly after walking alone at least 6 months Now___Past___Never___

Seems fearful of bumpy or uneven ground after walking alone for at least 6 months Now___Past___Never___

Stands or walks on toes frequently Now___Past___Never___

Falls frequently or easily Now___Past___Never___

Shifts weight constantly. Can't seem to sit or stand still Now___Past___Never___

Gets "sick" when tossed around Now___Past___Never___

Usually leans on objects or lies down when playing Now___Past___Never___

Seems very weak when doing some things but very strong at others Now___Past___Never___

Constantly "forgets" from day to day how to do things Now___Past___Never___

Has poor posture, slouches Now___Past___Never___

Shows shakiness in fine movements Now___Past___Never___

Refuses to run or be moved quickly Now___Past___Never___

Scoots on bottom to get places Now___Past___Never___

Is very clumsy Now___Past___Never___

Sits and rocks self repeatedly Now___Past___Never___

"Gives up" or gets frustrated easily Now___Past___Never___

Frequently stiffens arms and legs in unusual way Now___Past___Never___

Bangs his/her head repeatedly Now___Past___Never___

Only hits or throws toys Now___Past___Never___

Ignores toys Now___Past___Never___

Moves constantly from one object to another randomly without playing with them Now___Past___Never___

Shows aggressive behavior for no reason Now___Past___Never___

Becomes easily upset and takes a long time to calm down Now___Past___Never___

Responds very passively to things or people around him/her (does not play, look around or reach for) Now___Past___Never___

Dislikes being handled; prefers to be left alone Now___Past___Never___

Pulls away or becomes upset when approached quickly Now___Past___Never___

Violently fights having face washed Now___Past___Never___

SAMPLE
(cont.)

V. SPEECH AND LANGUAGE

Does child respond to your voice even when he/she cannot see you? Now___Past___Never___

Does child seem to hear the following:
- door slamming Now___Past___Never___
- telephone ringing Now___Past___Never___
- paper rattling Now___Past___Never___
- his own name Now___Past___Never___

Does child seem to hear better on some days than on other days? Now___Past___Never___

Has your child had a hearing test? Yes___No___
If yes, where? ____________________
____

Does your child babble? (connect strings of sounds) Now___Past___Never___

Does child use single words, name object or people? Now___Past___Never___

If child uses only single words or two-word combinations, how many words does he/she use?
- fewer than 10 words? Yes___No___
- 10 to 25 words? Yes___No___
- 26-50 words? Yes___No___
- over 50 words? Yes___No___

Does child use some word combinations? Yes___No___

Does child leave words out of sentences? Now___Past___Never___

Does child stutter? Now___Past___Never___

Does child receive speech therapy? Now___Past___Never___

VI. LEARNING

Does your child presently attend any infant stimulation, preschool or school program? Yes___No___
If yes, is it a regular classroom or a special program of some kind?
- regular classroom Yes___No___
- special program Yes___No___

At what age did child first attend a preschool or school program? __________

Does child resist going to school in the morning? Yes___No___

If there are grades, what grade is child in now? __________

Does child's school use letter or number marks for grading achievement?
- letter marks Yes___No___
- number marks Yes___No___
- other_______ Yes___No___

If school uses letter or number marks for grading, what mark does your child get most frequently? __________

Has child ever repeated a grade? Yes___No___
If yes, what grade? __________

Has child's teacher ever suggested that he might have a learning problem? Yes___No___

Does child play with toys? Yes___No___

Does child watch television? Yes___No___

Does child feed self with fingers? Yes___No___

Does child feed self with spoon? Yes___No___

VII. PERSONAL CARE

Does child still wear diapers? Yes___No___
How often? __________

If child wears training pants, does he/she have accidents? Yes___No___

Do you feel you and the child are ready for toilet training? Yes___No___

Do you have a potty seat where the child could sit comfortably? Yes___No___

IV. SENSORY DEVELOPMENT (cont.)

Protects self with arms when falling Now___Past___Never___

Uses both arms and legs well together Now___Past___Never___

Takes everything to his/her mouth as a means of exploring Now___Past___Never___

Plays with his own body parts (e.g., tummy, toes, genitals, etc.) Now___Past___Never___

Spends time repeatedly exploring objects in his/her environment (e.g., push pull, close open, poke with finger, rub, etc.) Now___Past___Never___

Cries when falls and hurts self Now___Past___Never___

Walks stiffly or awkardly after walking alone at least 6 months Now___Past___Never___

Seems fearful of bumpy or uneven ground after walking alone for at least 6 months Now___Past___Never___

Stands or walks on toes frequently Now___Past___Never___

Falls frequently or easily Now___Past___Never___

Shifts weight constantly. Can't seem to sit or stand still Now___Past___Never___

Gets "sick" when tossed around Now___Past___Never___

Usually leans on objects or lies down when playing Now___Past___Never___

Seems very weak when doing some things but very strong at others Now___Past___Never___

Constantly "forgets" from day to day how to do things Now___Past___Never___

Has poor posture, slouches Now___Past___Never___

Shows shakiness in fine movements Now___Past___Never___

Refuses to run or be moved quickly Now___Past___Never___

Scoots on bottom to get places Now___Past___Never___

Is very clumsy Now___Past___Never___

Sits and rocks self repeatedly Now___Past___Never___

"Gives up" or gets frustrated easily Now___Past___Never___

Frequently stiffens arms and legs in unusual way Now___Past___Never___

Bangs his/her head repeatedly Now___Past___Never___

Only hits or throws toys Now___Past___Never___

Ignores toys Now___Past___Never___

Moves constantly from one object to another randomly without playing with them Now___Past___Never___

Shows aggressive behavior for no reason Now___Past___Never___

Becomes easily upset and takes a long time to calm down Now___Past___Never___

Responds very passively to things or people around him/her (does not play, look around or reach for) Now___Past___Never___

Dislikes being handled; prefers to be left alone Now___Past___Never___

Pulls away or becomes upset when approached quickly Now___Past___Never___

Violently fights having face washed Now___Past___Never___

SAMPLE
(cont.)

IX. SOCIAL (cont.)

Does your family get food stamps? Yes___No___

Do you get additional money from other sources than your wages? Yes___No___
- investments? Yes___No___
- child support or alimony Yes___No___
- social security? Yes___No___
- other? specify? ___________
  ____

Do you ever leave the child with a babysitter so you can go out by yourselves? Yes___No___

Do you have difficulty finding an adequate babysitter? Yes___No___

Have you had to change your child's babysitter more than 3 times in the last 6 months? Yes___No___

Who spends the most time taking care of this child? ___________

Is your child fun to play with? Yes___No___

At what age level do you feel this child is functioning? ___________

Do the child's parents have arguments about his condition or care? Yes___No___

Do you have arguments with family relatives (grandparents, aunts, uncles, etc.) about his/her condition or care? Yes___No___

Do your other children resent the attention this child gets? Yes___No___

Does the care for this child make it difficult for you to give adequate attention to your other children? Yes___No___

Have there ever been any legal actions involving this child? Yes___No___

Does the care of this child make any health problems of the father worse? Yes___No___

Have any family members had psychiatric or mental problems? Yes___No___

Does either parent have any physical disability that makes it difficult to care for this child? Yes___No___

Do any family members drink too much alcohol (beer, wine, etc.)? Yes___No___

Do any family members abuse or overuse drugs? Yes___No___

SECTION THREE

STAFFING AND RELATED SERVICES

Part 1: INTRODUCTION

Staffing is thought by many to be the single most important element of a special education program for the severely and profoundly handicapped student. Staff and related service personnel include all professionals, paraprofessionals, volunteers, and other individuals who work with the child. The teacher of the severely and profoundly handicapped plays a critical role in the most effective utilization of those staff members who can best serve the needs of the child. To best use the personnel available, the teacher should have access to job or role descriptions that enumerate those persons and describe their responsibilities and contributions to the assessment, programming and evaluation of the child. (Role descriptions are important in promoting a clear understanding of responsibilities.) Professional expertise is vital in the assessment of the severely handicapped because of both the degree of disability and the complications of multiple handicaps. Programming involves the supportive services of the paraprofessionals and other ancillary personnel. Evaluation by all concerned parties provides a basis for future planning and continuity in the child's program. This multidisciplinary approach is essential for the optimal education of the severely and profoundly handicapped child or youth.

In listing or defining the roles of professionals, paraprofessionals and others, the teacher encounters a myriad of terminology, some familiar, some recently developed. Many job titles are not among those delineated in state rules and regulations; many are drawn from fields other than education. For severely and profoundly handicapped children, professionals from other fields are an essential part of providing necessary services. With unusual, complicated and/or medical problems, this population requires specialized diagnosis, planning and treatment. These students experience a higher incidence of behavioral problems, health problems, communication disorders, deficits in social skills and slower rates of development than do other special education recipients. The most severely affected may have handicaps in all or almost all of these areas.

In compiling the following titles the various specialties are recognized. Certainly not all of them exist in every state, and they are not offered as a statement of services existing in Arizona, but as suggestions of some ways of meeting the needs of the severely and profoundly handicapped. They are suggestions for starting points from which the teacher might proceed to attempt to solve some of the problems encountered in serving these students.

Administrators need to be involved in devising ways to coordinate services from the various agencies serving these children. Principals are critical in the commitment to and success of a program for this population.

The regular education teacher and staff can assist in finding ways of integrating the handicapped child with or exposing him/her to the experiences of the usual school program.

The special education teacher, depending on the decision of the local school district, might be the child study team leader. Teacher-specialist is another designation to denote particular expertise. As educational synthesizer, the special educator puts together and coordinates plans and services. The teacher of the severely and profoundly handicapped must have competencies in developing appropriate curriculum, behavior management, medical management, and skills in coordinating services with other professionals.

The early childhood consultant, as described in Project CHAIN,[1] is "primarily concerned with curriculum in the areas of cognitive and social/emotional development. The educator does individual assessment in these areas and recommends both programs and activities designed to further development. In addition, the educator serves as a consultant to the classroom teacher on issues such as classroom management and scheduling, behavior management, and programming strategies."

---

[1] Project CHAIN (Arizona Department of Health Services, Bureau of Child Development) is a demonstration classroom, providing educational services for children between ages 5 and 8.

In the area of reading there are the reading specialist, the reading consultant, the remedial reading teacher or the special reading teacher.

"The physical therapist has assessment and curriculum responsibilities for motor programs. The instructional objectives developed follow developmental sequences. When appropriate, the physical therapist recommends and/or designs adaptive equipment such as wheelchairs, scooterboards, proneboards, crawlers, etc."[2] The physical therapist might plan a program to control postural deviations and increase function.

"The occupational therapist is primarily concerned with assessment and curriculum in the areas of fine motor function and sensory integration. She/he may assist in developing adaptive devices."[3] Other responsibilities as a vocational rehabilitation counselor might include liaison with the community, prevocational and vocational skill training and knowledge of vocational opportunties.

"The speech and language therapist has assessment and curriculum responsibilities in at least two areas: dependent feeding and communication development. The dependent feeding skills are assessed on all children, with recommendations then made for adaptive feeding techniques and devices. All children are assessed for a variety of levels of communication development, including oral and non-oral means. Some children are taught through a Total Communication approach and others are instructed in the use of elementary communication boards. Still others are at more elementary levels of learning to turn toward sound and indicating choice by eye pointing."[4]

The communication therapist or specialist might perform some of the same services, including evaluation of the ability to receive, organize, understand and produce or use a language system (verbal or nonverbal).

The recreational therapist assesses the child's skills, interests and needs in terms of leisure and recreation activities, developing adaptive devices and planning for the acquisition of increased skills and higher functioning.

---

[2] Project CHAIN
[3] Ibid
[4] Ibid.

Akin to the role of the recreational therapist is that of the *adaptive physical education specialist* whose area of expertise is the development of motor and physical fitness, motor skills, recreational and sport activities.

Also in the area of motor development is the *mobility specialist* who, in addition to assessing motor skills development, evaluates and assists in the development of the child's perception of the environment and the ability to move as freely as possible. This specialist is frequently, but not exclusively, involved with the vision impaired.

The *pediatric therapist* as described by Cynthia Stone (cited in Haring, 1977) is a consultant with expert knowledge in motor skills who can work with the staff in evaluating those skills in a developmental continuum and integrating therapy into the educational program.

The *educational diagnostician* might provide testing services in the schools. Depending on state regulations, this person might evaluate test results and make recommendations based on those results.

The *social worker* might provide services for both individual and family welfare, including child care, financial assistance, and assistance in locating needed services in the community. The social worker could have an extensive knowledge of sources to which the family might turn for other needed services outside the school system.

The *psychologist* or *school psychologist* provides diagnosis, testing services, interpretation of those results, and perhaps counseling or therapy on both an individual and group or family basis. The *psychologist* could evaluate in terms of the functional level of the student. The *behavioral psychologist* could relate principles of behavior to the educational environment. The *behavior therapist* might be utilized in the modifying of undesirable behaviors and the learning of acceptable social skills.

The *counselor* might be a member of the staff in the role(s) of *vocational counselor*, *career counselor*, *peer relations counselor*, *parent*, or *family counselor*.

Because of the high incidence of physical problems among severely and profoundly handicapped children, there might be need for medical expertise other than that of the *physician*. Early diagnosis and therapy might require the services of the *neonatologist*. The *pediatrician* and *pediatric neurologist* are two early childhood specialists. The *orthopedic surgeon* specializes in injuries to or malformations of limbs. The *neurologist* specializes in brain and nervous system disorders. The *urologist* treats urinary tract problems. The *psychiatrist* deals with emotional problems, especially those of suspected physical origin or those requiring medical treatment. The *cardiologist* specializes in heart ailments; the *plastic surgeon* repairs physical deformities; the *ophthalmologist* specializes in treatment of eye problems; the *otolaryngologist* treats disorders of the eyes, nose, throat and related areas. The *dentist* or *orthodontist* is concerned with care of mouth and teeth and corrections of deformities. The *audiologist*, a hearing specialist, might team with the *speech therapist* for communication therapy.

The paraprofessional staff includes persons such as *foster grandparents*, *volunteers*, *instructional assistants*, *aides* and *parents*. These individuals perform services which can make the difference between a marginal program and one which provides outstanding service for the children. An example of an aide training program is given in Appendix F.

The number of roles that can be filled on behalf of the severely and profoundly handicapped child is impressive. This is to be expected in view of the number and degree of disabilities. Attempting to define those roles is, in many cases, an exercise in semantics, for the state or school district must exercise its prerogatives in delineating *its* definition of roles and choice of titles it feels best fit those roles. As mentioned in the introductory paragraph, this material is intended as a broad view from which to select ideas for possible ways to solve the very difficult problem of evaluating, planning for and serving the handicapped child.

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SAMPLE

Staffing and Related Services. Fill in the names of persons available to support the assessment, programming and reevaluation of students.

	(Name) Personnel	Full Time	Part Time	Not Available	When Obtainable
Administrators/ Principals					
Regular Education Teacher					
Special Education Teacher					
Teacher/ Specialist					
Educational Synthesizer					
Early Childhood Educator/Consultant					
Reading Specialist, etc.					
Physical Therapist					
Occupational Therapist					
Vocational Rehabilitation Counselor					
Speech & Language Therapist					
Communication Therapist					
Recreational Therapist					

SAMPLE
(Cont'd)

	(Name) Personnel	Full Time	Part Time	Not Available	When Obtainable
Adaptive Physical Education Specialist					
Mobility Specialist					
Pediatric Therapist					
Educational Diagnostician					
Social Worker					
Psychologist					
Counselor					
Physician					
Medical Specialist					
Dentist					
Audiologist					
Foster Grand-parents					
Volunteers					
Aides					
Parents					

SECTION FOUR

INDIVIDUALIZED EDUCATION PLAN

Part 1: INTRODUCTION

Education of the severely and profoundly handicapped is a complex task. Many educators look upon the Individualized Education Program (IEP) as still another administrative task to subtract from the time and energy that could be devoted to educational programming. Edgar (cited in Haring, 1977) suggests that most competent teachers are already performing many of the operations involved in the IEP and that its formulation and use are a part of any good educational program. With certain guidelines clearly established, the IEP committee should be able to do its work with the most efficient use of members' time and energies.

Assessment information should be gathered and summarized as outlined in Section Two. Following assessment, the priorities or annual goals are established. The committee then decides how the goals are to be attained and makes recommendations about the placement where the services can best be delivered. All of these processes need to comprise a continuum of assessment, planning and reevaluation with optimal coordination and communication among the IEP committee members. This process need not be awesome if the committee members develop their individual areas and are well prepared with the diagnostic and prescriptive information for the team meeting. According to Torres (1977), interaction of staff prior to the final IEP meeting should be directed toward reconciling possible discrepancies of evaluative results to avoid serious disagreements at the IEP meeting. The team should include parents on a coequal basis with other team members. The aim of the IEP meeting should be to have all participants committed to contributing the very best they have to offer. The complexities of educating the severely and profoundly handicapped require that high level of energy and expertise.

Part 2: CURRENT PRACTICES

The complexity of planning for the severely and profoundly handicapped student calls for the involvement of many professionals and paraprofessionals in the development of the individualized educational plan (IEP). Public Law 94-142, The Education for All Handicapped Children Act of 1975, requires the minimal membership on the IEP committee of teacher, administrator and parent(s), plus a member of the assessment team (or someone who can interpret the assessment results) for the first IEP following the assessment. Arizona State Board of Education Rules and Regulations read as follows:

> An individualized education plan must be developed for every handicapped child prior to placement in a special education program. For children continuing in special education placement from the prior school year, the individualized education program plan must be reviewed annually and revised if necessary. The individualized planning conference may be held concurrently with the multidisciplinary conference and must include a representative of the LEA[1] and SSI,[2] the child's teacher(s), one or both parents, and where appropriate, the child. The individualized education plan for each child must include:
>
> a. A statement of the child's present levels of educational performance;
> b. A statement of annual goals;
> c. A statement of short-term instructional objectives;
> d. A statement of the specific special education and related services to be provided to the child;
> e. A description of the extent to which the child will be able to participate in regular education programs;
> f. The projected date for initiation and anticipated duration of services; and
> g. Appropriate objective criteria, evaluation procedures, and schedules for determining whether instructional objectives are being achieved on at least an annual basis. (R7-2-401E.9)

To elaborate on the above seven points of the IEP:

a. The assessment information must be as current and as accurate as possible, the latter a distinct challenge due to the difficulty of assessing severely and profoundly handicapped children. The assessment should include, at a minimum, information on gross motor, communication, social, self-help and cognitive skills, health status, behavioral profile and learning style. Such information is stated as present levels of educational performance.

---

[1] LEA: local educational agency (public school)

[2] SSI: state supported institution

b. Annual goals are related to the present level of performance. Selection of annual goals is an effort to avoid unproductive or aimless programming. Parents should help formulate the goals.

c. Short-term instructional objectives are steps, means by which the annual goals are attained. Objectives are useful when stated as specific behavioral criteria. They must be measurable and realistic.

d. Specific services the child is to receive and special devices needed by the child are enumerated. The severely and profoundly handicapped child must receive physical education which might be offered in the form of occupational or physical therapy. Communication skills are frequently lacking and development of these skills is a cornerstone to the attainment of other skills. (See Part 4: SAMPLE FORMS for definition of related services.)

e. The appropriate integration of the child into regular education programs must be considered. When the IEP committee decides interaction would be possible and of benefit, it will specify how such interaction will be made possible, and the amount or percentage of time that will be spent in regular programs.

g. The committee will state how criteria will be determined, how performance will be evaluated and the date within one year or less for the committee's reevaluation of the IEP.

Part 3: SELECTED BIBLIOGRAPHY

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Torres, S. (Ed.) *A primer on individualized education programs for handicapped children*. Reston, Virginia: Council for Exceptional Children, 1977.

Information gained from assessment can be used to initiate the development of the IEP. The individual(s) responsible for amassing the information and submitting it for the IEP team's action should insist that assessment summaries deal with educational programming. The format for the IEP may vary as long as the items prescribed by law are included.

SAMPLE

PLACEMENT AND IEP CHECKLIST

_____Referral
_____Parent Permission to Test
_____Evaluation
_____Designation of IEP Participants
    _____LEA Representative Other Than the Child's Teacher*
    _____Parent, Surrogate Parent, or Guardian*
    _____Regular Teacher or Special Education Teacher*
    _____Diagnostician
    _____Other
_____Scheduling Meeting at a Mutually Agreeable Time and Location
_____Meeting Scheduled to Develop Mutually Acceptable IEP, Including:
    _____Present Functioning Levels
    _____Long-Term Annual Goals
    _____Short-Term Instructional Objectives
    _____Criteria for Evaluations
    _____Specific Educational and Related Services
    _____Degree of Involvement in Regular Education
    _____Projected Date to Initiate Services
    _____Duration of Services
    _____Evaluation Procedures
_____Committee/Placement Decision
_____Parent Permission to Place
_____Review and Evaluate IEP (Minimun annually)
_____Review and Evaluate Placement (Minimum annually)

*Participation required.

NOTE: Regardless of which procedural option is selected in the development of the IEP, all items should be completed.

SAMPLE

HOW TO DETERMINE WHAT IS A RELATED SERVICE AND HOW EDUCATION WILL FULFILL ITS RESPONSIBILITY

Developed by a National Association of State Directors of
Special Education (NASDSE) task force at the
Southwest Regional Resource Center, Salt Lake City, Utah,
May 3, 1979

I. Defining a related service:

A. Conditions

1. IF the service is necessary for the child to benefit from special education,
2. AND IF the need for service is articulated descriptively in the assessment of the child,
3. AND IF the service is consistent with state educational agency standards,

THEN the service is a related service and it is the district's responsibility to see that it be provided at no cost to the parent in the least restrictive environment.

Process Service	Examples of Related Services		Examples of Non-related Services	
	Assessment	IEP	Assessment	IEP
Audiology				
Counseling				
Early Identification				
Medical				
Occupational Therapy				
Parent Counseling & Training				
Physical Therapy				
Psychological				
Recreation				
School Health				
Social Work				
Speech Pathology				
Transportation				
Others; e.g., art, music, dance, etc.				

SAMPLE
(Cont'd)

II. Defining education's financial responsibility for related services provided by a licensed physician.

A. Conditions to be met (criteria):

1. "Medical Services"
   IF a licensed physician provides evaluation or assessment services AND IF the evaluation is not paid for by another agency, THEN education must pay.
2. Other related services
   IF the district chooses to use a licensed physician to provide the service, consistent with state regulations, AND IF the service is not paid for by another agency, THEN education must pay.

Process Service	Examples when districts must pay for other related services provided by a licensed physician		Examples when districts may pay for other related services provided by a licensed physician	
	Assessment	IEP	Assessment	IEP
Medical				

SAMPLE

Arizona

INDIVIDUAL EDUCATION PLAN

S A M P L E

Name of Student ______________________
Date of Birth ______________________
School ______________________

Date of Meeting ______________________

Present Levels of Educational Performance (include strengths and weaknesses in all areas pertinent to child - academic, behavioral, self-help, prevocational, etc.)

STRENGTHS	WEAKNESSES	CURRENT ACHIEVEMENT/ BASELINE DATA

Annual Goals

____
____
____
____
____
____
____
____
____
____

Short Term Objectives (specify at least one per goal)

Services to be Provided
A. Special Education: ______________________
____
B. Related Services:
Transportation ____
OT ____
PT ____
Speech ____
Adaptive P.E. ____
Social Work ____
Counseling ____
Medical ____
Audiology ____
Specify ____________ ____

Initiation and Duration
Dates of Services
A. ________ ________
B.

Objective Criteria & Evaluation Procedures of whether objectives are achieved (include revision dates)

Description of the extent of involvement in the Regular Classroom (include all activities in which the child participates with non-special education students)

A: Academic	B: Extra-Curricular

Other Modifications ______________________
____
____

IEP Review Date

Signatures of Participants	Date	Role in Meeting
		Representative of agency
		Child's Teacher
		Parent
		Parent

SECTION FIVE

CURRICULAR OPTIONS

Part 1: INTRODUCTION

The curriculum for the severely handicapped is a comprehensive curriculum, one that encompasses the entire life functions of the child or youth. Teaching the severely or profoundly handicapped child to function within the environment to the child's potential will very often involve training in any skill used in the basic functions of everyday life. The child may be severely limited in certain areas, but assessment and programming might indicate that, with proper training, the child's level of functioning could be much higher and provide a greater degree of self-sufficiency. The procedure is to build from the present skill level to development of those skills that the child lacks.

Development of curriculum is a difficult task. Williams and Gotts (1977) suggest that curriculum development start in a small area that lends itself to relatively quick and easy development. This will set the stage for other tasks. Fredericks, et al. (1975) individualize curriculum and then generalize from it for other children as appropriate to utilize the teacher's time as efficiently as possible.

Generally, the procedure to match the curriculum to the child is to identify: 1) objective for each student; 2) teaching strategy; and 3) criteria for child change, accomplishment of objective.

Many curricula need to be examined as appropriate for a developmental level and sequence rather than for an age group. To provide the best curricula for a child the following steps are recommended:

1. Evaluate existing curriculum based on match with child needs
2. Select appropriate curriculum
3. Modify curriculum
4. Develop curriculum
5. Evaluate, and modify, if necessary

Current curriculum practices for severely handicapped persons are built around specific categories. These skills include:

1. Self-help
2. Communication
3. Academics
4. Motor and physical education
5. Personal and social
6. Independent living and vocational development

Curriculum format for this population is uniquely designed, based on skill level task analysis. The scope and sequence of the curriculum objectives are designed to move in the smallest necessary increments from nonfunctioning to independent functioning. The designed curriculum includes activities of observable behavior change. No one curriculum will be suitable for all children; the professional must draw from many curriculum sources to design appropriate programs.

I. Identifying Curricula

Many curricula need to be looked at as appropriate for a developmental level and sequence rather than for an age group, e.g.:

A. Early Self-Help Skills by Bruce L. Baker. This 79-page resource guide is designed to help parents teach basic motor skills and self-help skills such as dressing, grooming, and eating to their children with special needs. The book is divided into two sections. The first section, "Principles and Methods," provides a general understanding of behavior modification as well as specific rationales for parental responsibility in teaching. Topics such as choosing a target skill, selecting rewards for learning, setting up the teaching program, using rewards and record-keeping are presented. The second section, "Programs and Activities," provides specific steps and suggestions to follow in teaching skills in six areas. From the "Steps to Independence Series." Research Press, 1976, Box 3177J, Champaign, Illinois 61820.

B. An Education Curriculum for the Moderately, Severely, and Profoundly Mentally Handicapped by Jane L. Adams. This 80-page paperback book is designed to provide an outline and specific activities for classroom curriculum for students functioning at an early childhood through primary level. The book is arranged around five developmental areas: self-help skills, cognitive skills, motor skills, communication skills, and social skills. Exercises and activities in these areas ask the students to respond to verbal directions regarding toilet training, verbalize and find the correct date on the calendar, recognize the numerals 1 to 20, and participate in group game activities such as ball rolling. Behavioral modification procedures are an integral part of the programmed activities. The text also includes language development activities and a section on appreciation of behavior modification techniques. Charles L. Thomas, 1975, 301-327 East Lawrence Avenue, Springfield, Illinois 62727.

C. I Can Physical Education Program by Janet A. Wessel. "I Can Physical Education Program" is an individualized instructional preschool-through-secondary-school physical education curriculum program covering skills in four major areas: the "I Can Fundamental Skills," the "Body Management Skill Area," the "Health/Fitness Package," and the "Aquatic Skill Area." Two guides, "I Can Teacher's Guide" and "I Can Curriculum & Planning" provide the steps and decision criteria necessary to define and implement this program. The Bureau of Education for the Handicapped funded the I Can Program which was field-tested and developed by the Field Services Unit in Physical Education & Recreation, Michigan State University (Lansing, Mich.) under the direction of Janet A. Wessel. The set for each skill is packaged in a box and includes two notebooks of instructional activities, a teacher's guide, two sets of game activity cards, class performance record sheets, and individual achievement record sheets. Hubbard Scientific Co., 1976, 1946 Raymond Rd., Northbrook, Illinois 60662.

D. The Radea Program. The program contains 56 cards, 3 cassettes, profile charts, and worksheets. These materials are designed to increase the adaptive behaviors of students of developmental levels 0 through 7 years. The materials consist of six subject areas, each of which is divided into four developmental levels. The areas are visual perception, auditory perception, perceptual motor, oral language, functional living, and special problems such as echolalic speech (automatic repetition of heard sounds), swallowing, self-stimulation, toilet training, and drooling. Level 1 corresponds to skills normally learned from ages 0 through 2; level 2, ages 2 through 3½; level 3, ages 3½ through 5; and level 4, ages 5 through 7. Melton Book Company. Melton Peninsula, Inc., 1949 Stemmons Freeway, Suite 690, Dallas, Texas 75207.

E. A Step-by-Step Learning Guide for Retarded Infants and Children by Vicki M. Johnson and Roberta A. Werner. This 195-page paperback book is designed to provide curriculum activities in a variety of target areas for students with a chronological age of from 1 to 12 and a functional level of less than 4 years. The target skills are categorized into 8 areas: fine motor skills, language skills, self-care skills, gross motor skills, nonverbal and verbal initiation skills, social skills, and sensory stimulation. The 240 tasks identified are categorized by the type of activity they represent and ordered sequentially by difficulty level. Entry level behaviors are also specified for each task. Students are asked to participate in activities such as responding to verbal cues, dressing and undressing, and following directions to perform manipulative tasks. The book also seems appropriate for use by parents. Syracuse University Press, 1975, 1011 E. Water St., Syracuse, New York 13210.

F. Steps to Independence by Bruce L. Baker. This series of 4 resource guides and a 21-page guide for their use is designed to help parents of special children use behavioral modification techniques to teach self-care skills and develop behavior control. The guides are entitled "Early Self-Help Skills," "Intermediate Self-Help Skills," "Advanced Self-Help Skills," and "Behavior Problems." Suggestions are provided for step-by-step development of skills. Numerous examples, illustrations, and diagrams are included for clarification of concepts and procedures. The guide provides a description of the series, guidelines for establishing a parent training program, a performance inventory of self-help skills, and sample checklists and charts for recording skill levels and progress. Research Press, 1976, Box 31775, Champaign, Illinois 61820.

G. Telecommunications Project for Severely Handicapped Children and Youth by Teaching Resource Telecommunications. This set of 14 20-minute, color videotape recordings is designed to be used with the Responsive Television instrument to provide an introduction to self-help skills and concept development skills for students with a chronological age range of 6 to 18 years and a mental age range of 2.0 to 6.7 years. The recordings are intended to be used as support materials for institutionalized and homebound students. The videotape recordings are divided into two parts: the self-help skills program and the concepts development program. The first includes six recordings: "Introduction," "Handwashing," "Using a Spoon," "Drinking from A Glass," "Preparing Your Toothbrush," and "Brushing Your Teeth." From the Telecommunications for Severely Handicapped Children and Youth Program Series. Teaching Resources Corp., 100 Boylston St., Boston, Massachusetts 02116.

H. Behavioral Characteristics Progression (BCP): The Santa Cruz Special Education Management System (SEMS). An assessment, instructional and communication tool utilizing a continuum of behaviors in chart form. The end of the behavioral continuum approximates appropriate behaviors. The VORT Corporation, P. O. Box 1132, Palo Alto, California 94306.

I. "Motor Programming for the Severely Handicapped" by R. A. Keen and S. Sullivan. In E. Somerton and K. Turner (Eds.). Assessment and Curriculum for the Severely Handicapped. Describes and illustrates positioning and handling techniques appropriate for feeding, dressing, and toileting the severely handicapped, dependent individual in as therapeutic a manner as possible. Techniques are well illustrated and explained for parents, child care workers, and teachers (from Haring). Reston, Virginia: Council for Exceptional Children, in press.

J. "Positioning and Feeding the Handicapped Child." In E. Sontag, N. Certo and J. Smith (Eds.). Educational Programming for the Severely and Profoundly Handicapped. Provides general guidelines for implementing positioning and feeding program and illustrates program implementation through a series of case studies. Reston, Virginia: Council for Exceptional Children, 1976.

[1]K. Curriculum and Monitoring System by J. Jones, et al. The areas covered are receptive language, expressive language, motor, self-help and social-emotional. The format is placement tests for each area; task-analyzed instructional objective with teaching procedures, photographs of body positions in motor and self-help sections. The developmental level includes young children, approximately 0 to 6 years. Logan, Utah: Utah State University Affiliated Exceptional Child Center, 1977.

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[1] Items K through X were prepared by Diane Renne in "Curriculum Guides for Developmentally Disabled Children: Severely Handicapped and Early Childhood." From Administrators Resource Manual for the Deinstitutionalization of Children and Youth, 1979.

L. Developmental Programming for Infants and Young Children ed. by D. S. Schafer and M. D. Moersch. The areas covered include perceptual/fine motor, cognition, language, social/emotional self-care and gross motor. The format is developmental profile; short term goals; suggested activities; recommended adaptations for hearing, vision and motor impairments. The developmental level is newborn through 36 months. Ann Arbor, Mich.: The University of Michigan Press, 1977.

M. Developmental Teaching Guide ed. by D. S. Schafer and M. D. Moersch. The areas covered include self-help, language, motor, social, orientation and mobility. The format is developmental checklist; activity file with activities matched to each item on the checklist. The developmental level is not specified; intended for use with visually impaired multiply handicapped children birth to 8 years. Boston: Boston Center for Blind Children, 147 South Huntington Ave.

N. Guide to Early Developmental Training by Wabash Center for the Mentally Retarded. The areas covered include motor, cognitive, self-care, language. The format is assessment checklists; suggested activities for each of the skills covered in the checklists. The developmental level is birth through 6 years. Lafayette, In.: Wabash Center Sheltered Workshop.

O. Language Acquisition Program for the Retarded or Multiply Impaired by L. R. Kent. The areas covered include preverbal, verbal-receptive, verbal-expressive, sign language and total communication. The format consists of sequential teaching tasks with procedures and criteria specified. The developmental level is not specified. Champaign, Ill.: Research Press, 1974.

P. Parent/Child Home Stimulation, "The Marshalltown Project," by Donahue, et al. The areas covered include communication, motor and social stimulation. The format is assessment profiles; prescription for each item on the profile including behavioral definition, appropriate cues, measurement criteria, materials-sequenced subobjectives, teaching strategies. The developmental level is birth through 6 years. Marshalltown, Iowa: Department of Special Education, Marshall-Poweshiek Joint County School System, 9 Westwood Drive.

Q. The Portage Guide to Early Education by D. Shearer, et al. The areas covered include infant stimulation, socialization, language, self-help, cognitive, motor. The format is a checklist of skills in each area; curriculum card for each skill on the checklist.' The developmental level is birth through 6 years. Portage, Wisc.: CESA 12, Box 564, 1976.

R. A Prescriptive Behavioral Checklist for the Severely and Profoundly Retarded by D. Popovich. The areas covered include motor development, eye-hand coordination, language development and physical eating problems. The format consists of a sequential checklist of skills in each area; instructional objective task analysis, description of materials, prerequisite skills, and procedures for each skill on the checklist. The developmental level is not specified; all skills appear to be preschool level. Baltimore: University Park Press, 1977.

S. Project Memphis: Enhancing Developmental Progress in Preschool Exceptional Children by A. D. Quick, T. L. Little and A. A. Campbell. The areas covered include personal-social, gross motor, fine motor, language, perceptuocognitive. The format is assessment scale, skill assignment record, continuous record of educational gain, sample lesson plans. The developmental level is newborn to 5 years. Belmont, Ca.: Fearon Publishers, 1974.

T. Severe/Profound Handicapped Children: An Integrated Activity System for Hand Function and Language by P. Babbit and D. Zimmerman. The areas covered include hand function and language. The format is screening checklists, activity card file with behavioral objectives, with materials and procedures for each activity. The developmental level is 3 months to 3 years. Albuquerque, N.M.: Esperanza Para Nuestros Ninos, P. O. Box 12212, 1976.

U. Step-by-Step Dressing by S. Henderson and M. McDonald. The areas covered include dressing and undressing. The format is sequences of steps for specific dressing skills, presented in chart form; sample lesson plans and teaching procedures. The developmental level is 1 to 6 years. Bellevue, Wash.: Edmark Associates, 1973.

V. The Teaching Research Curriculum for Moderately and Severely Handicapped by H. D. B. Fredericks, et al. The areas covered include motor development, receptive oral language, expressive oral language, self-help skills, reading skills, writing skills, and cognitive skills. The format consists of placement tests and task-analyzed teaching sequences. The developmental level is preschool. Springfield, Ill.: Charles C. Thomas, 1976.

W. Teaching the Moderately and Severely Handicapped by M. Bender and P. J. Valletutti. Vol 1: Behavior, Self-Care, and Motor Skills; Vol. 2: Communication, Socialization, Safety and Leisure Time Skills; Vol. 3: Functional Academics for the Mildly and Moderately Handicapped. The areas covered include behavior, self-care, motor, communication, socialization, safety, leisure time skills and functional academics. The format consists of diagnostic checklists, general objectives, specific objectives, suggested activities for each specific objective. The developmental level is not specified. Baltimore: University Park Press, 1976.

X. Other Curricula

1. Alpern and Boll, Education and Care of Moderately and Severely Retarded Children.

2. Cibiri and Jackson, Training Developmentally Handicapped Persons, Basic Life Skills.

3. Martin, et al., The MIMR Basic Behavior Test, Curriculum Guide, Programming Strategy.

4. McCormack and Chalmers, Systematic Instruction of the Severely/Moderately Handicapped.

II. Evaluating Curricula

A. Comprehensiveness. A curriculum should be comprehensive, covering all possible activities for the handicapped child. (See the sample comprehensive curriculum later in this section.)

B. Range. The curriculum should apply to all developmental ages being served and to all types of handicapping conditions represented in the program.

C. Sequence. A curriculum should be sequenced, starting with low-level skills and progressing in small sequential steps to higher-level skills.

D. Task Analysis. The curriculum should be task-analyzed to facilitate sequential learning.

E. Methodology. A curriculum should include suggested methodology. This is the "how to" which would include activity cues, amount of assistance given, when to deliver reinforcer, etc.

F. Accountability. Objectives should be stated with measureable outcomes to insure accountability.

G. Philosophy. The philosophy underlying the curriculum should be acceptable to parents and teachers.

H. Parent Involvement. Purposeful parental involvement in the educational process should be included.

III. Modifying Curriculum

A. Elimination or addition of sequential skill levels.

B. Consideration of student entry level, experiential base, need for skill transfer and practice.

C. Considerations of environmental adaptations to meet curriculum objectives.

D. Modifications of the curriculum to meet the needs of the student's most effective learning period.

E. Adaptation of the curriculum to staffing patterns, utilization and expertise.

IV. Development of Curriculum

A. Select a curriculum that has desirable components.

B. From the curriculum guide, outline according to the previously discussed criteria the program you wish to initiate.

C. Adapt present objectives and write new objectives if needed.

D. Create task analyses of skills not previously broken down into sequential steps.

E. Include additional component steps in tasks that need smaller steps.

F. Check for accountability:

        1. Objectives have stated criteria
        2. Objectives can be measured

    G. Develop a continuous evaluation process and reprogramming model.

V. Sample Comprehensive Curriculum[2]

A comprehensive curriculum is a twenty-four-hour curriculum, and should include educational and life goals for the handicapped child. Following is a suggested outline of a comprehensive curriculum.

- I. Functional living skills: independent care of personal needs and safety.
    - A. Self-care
        1. Eating
        2. Dressing
        3. Personal hygiene
    - B. Safety and self-protection
    - C. Mobility
- II. Communication and language: interaction within the environment.
    - A. Attention and listening
    - B. Imitation
    - C. Reception
        1. Auditory
        2. Visual
    - D. Expression
        1. Verbal
        2. Manual
        3. Symbolic

---

[2] S. B. Harrison and M. Johnson, Establishing Services for the Severely Handicapped in Public Schools. Salt Lake City: University of Utah, Southwest Regional Resource Center, 1975.

III. Social skills: adjustment in relating with others in the environment.

IV. Motor skills: development of body control and purposeful, satisfying motor development.

   A. Motor

      1. Gross
      2. Fine

   B. Physical fitness

   C. Leisure and recreation

      1. Art
      2. Sports, etc.

V. Basic knowledge activities: meaningful use of functional skills.

   A. Reading

   B. Writing

   C. Computational skills--basic processes

   D. Functional number experiences

      1. Money
      2. Time
      3. Measurement
      4. Wages
      5. Payment
      6. Banking
      7. Tax

VI. Contributive skills: acquisition attitudes, habits and information to become a contributing member of society.

   A. Personal work adjustment

   B. Functional work skills

      1. Home
      2. School
      3. Shop and maintenance

   C. Occupational skills

1. Placement training
2. Sheltered workshop
3. Community work skills

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SAMPLE

CURRICULUM EVALUATION FORM[3]

A. Superficial level of materials.

1. Title____
2. Author____
3. Publishing company________________________________
4. Format____
5. Area of instruction________________________________
6. Service

durability	high	1	2	3	4	5	low
consumable	yes	no					

7. Attractive____
8. Convenience in handling and storage__________________

B. Content of materials.

1. Purpose/outcome___________________________________

   ____

2. Developmental age range____________________________

   ____

3. Does student require assistance? yes no

---

[3] Harrison and Johnson, Op. cit.

SAMPLE
(Cont'd)

4. Is there sufficient suggested methodology for use? yes no

5. Training in use:___teacher manual, ___some assistance, ___workshop

6. Can it be easily adapted in the degree or the complexity of the task to match various student needs? yes no

7. What is the primary input? ___Visual ___Tactile Kinesthetic

___Gustatory ___Auditory ___Olfactory

8. What is the primary process involved?

(circle) 1 as primary, 2 and 3 as supportive

	Visual	Auditory	Tactile-Kinesthetic
Attention	1 2 3	1 2 3	1 2 3
Identification	1 2 3	1 2 3	1 2 3
Discrimination	1 2 3	1 2 3	1 2 3
Association	1 2 3	1 2 3	1 2 3
Memory	1 2 3	1 2 3	1 2 3
Sequencing	1 2 3	1 2 3	1 2 3
Other _______________	1 2 3	1 2 3	1 2 3

9. Placement test? yes no

10. Teacher expertise:

no training needed 1 2 3 4 5 training needed

11. Is there built-in accountability? yes no

12. Aide use: high 1 2 3 4 5 low

13. Parent involvement: high 1 2 3 4 5 low

SAMPLE

CURRICULUM

Utilize as a curriculum planning sheet for each student.

Student Name____

Curriculum Area	Objective	Methods of Evaluation	Name of Curriculum	Objective	Evaluation
Self-Help	The student will drink from a cup on verbal request command	Drinks from cup daily	Behavioral Characteristics Progression (See Part 2)	4-11.0	3.0 Criteria
Communication					
Academics					
Motor/ Physical Education	Jump over rope that is 1" off floor	Mastery based on criteria	Radea	Task 70 Level 3	5/5
Personal and Social					
Independent Living and Vocational Development					
Other					

SAMPLE

STAFFING OPTIONS

Check the student placement most appropriate and note percentage of time spent in each location or in each service delivery mode.

	Student Names			
Regular Classroom				
Itinerant Teacher/ Consultant*				
Resource Room Teacher/ Specialist				
Self Contained Classroom				
Special Center/ School				
Outside Agency				
Homebound/ Hospital**				
Other				

*To render services to child and/or teacher

**Service delivered to child in residential or hospital setting

SECTION SIX
TEACHING STRATEGIES

Part 1: INTRODUCTION

Effective principles of or strategies for instruction should include readiness, motivation, results and reinforcement of success. Paramount to the success of teaching strategies is the planning for behavioral training and behavioral modification where necessary. Severely and profoundly handicapped persons exhibit behaviors which interfere with their success in acquiring skills, either because they appear to be incapable of succeeding or because such behaviors interfere with their interpersonal relationships.

Remediation of inappropriate behaviors and training in appropriate behaviors require orderly progressions through the phases of identification, gathering of baseline data, goal setting, program implementation, analysis of implementation data and generalization. Behavioral and task training must be planned to complement each other.

One method of achieving desired attainment of more "normal" behaviors would be the utilization of peer models and trainers. As with other facets of the education of the severely and profoundly handicapped, instruction must be carried out by trained individuals on a 24-hour schedule.

Part 2: CURRENT PRACTICES

Present-day teaching strategies for the severely, multiply handicapped student probably stem from progressive education, informal teaching in kindergartens, and specific studies related to optimum achievement by severely handicapped persons. Current teaching strategies tend to relate to two approaches, one being individualized and the other group oriented; however, some commonality exists between the two delivery systems. Several major instructional strategies are identified below; either individualized or group activities can incorporate these methods.

1. Individual and group control: emphasizing preventive aspects, helping the student develop self-control.

    a. Preventive control does not depend entirely on verbal reception, but leads the student by multi-input, such as tactile direction, for the desired outcome.
    b. Structure the environment and the teaching strategy based on preventive approaches to potential problem situations and behaviors.

2. On-task behavior: creating a situation in which the student starts the task, keeps on task and is motivated by the involvement.

    a. Use a process of sincere praise to bring a true feeling of achievement and success.
    b. Involve the student as a participant in the task rather than as a receiver of information.

3. Structuring the teaching/learning situation: providing for a specific sequence of involvement and interaction that is geared for student entry level and achievement.

    a. Develop a step-by-step strategy that is clearly directed toward objective assessment.
    b. Remain consistent with the structure for the student's total understanding of the activities that will occur.

4. Providing a mind-set or attention procedure.

    a. Secure the student's attention before entering into the activity.
    b. Acquire the student's receptive attention prior to any instruction or expectation of student output.

5. Task analysis of the skill content and of the problems in learner performance.

    a. Assure that the skill to be addressed is broken into the smallest appropriate subtasks for the student and that these subtasks include teaching steps in which individual tasks are reviewed and the generic concept is taught.
    b. Assure that analysis of the student has been implemented. (What skills must the learner have to accomplish the objective?) The complexity of this task analysis for the severely and multiply handicapped is ever changing through varied and interrelated influences due to fluctuation of learning behaviors.

6. Experiential-based strategies: providing for task learning based on student experiences.

    a. Build objectives on known, retained and transferable experiences.
    b. Provide for concrete experiences that relate to the teaching/learning objective.

7. Concrete-semiabstract-abstract: planning the teaching method based on the sequence of: the real experience; a representation of the experience; an abstraction of the experience.

    a. Provide an objective activity as the initial step to learning.
    b. Provide a visual or auditory representation of the skill for development of an inter-own concept.
    c. Move to an abstraction of the concept for a linkage to the skill.

8. Modeling for accomplishment: allowing for concurrent training of the student.

    a. First level of modeling: demonstrating the task, asking the student to respond.
    b. Second level (if the first level does not achieve child-change): either visual or auditory clueing, asking for student to respond.
    c. Third level: modeling accomplished by total modality input, physically including the student in the modeling process.

9. Behavior modification: selecting target behavior as appropriate; selecting and defining specific desired responses; immediately reinforcing correctly completed responses by some appropriate reward.

    a. If the response is not made, offer a modeling of the response.
    b. Establish learning sequence by continued specific rein-

forcement procedures.

10. Direct instruction: providing direct instruction requires an entry level, objective, attention, modeling and a situation in which repetition of the skill is necessary.

    a. Base the process of direct instruction on modeling, displaying or clueing the skill desired.
    b. Require response in relation to the skill, based on full attention and direction.
    c. Repeat the modeling, displaying or clueing, requesting the student response.

11. Visual/Auditory/Kinesthetic: using multimodalities in the teaching strategy allows for intersensory involvement.

    a. Provide the skill desired in a format of a visual, auditory or kinesthetic experience and request student response in the same modality.
    b. Phase out a modality as is appropriate for child change; however, always be able to implement the phased out modality when needed for skill accomplishment.

12. Clueing: providing modality clueing for a concept accomplishment.

    a. Provide a physical clue related to the skill desired (making clue as concrete as possible).
    b. Provide a visual clue related to the skill desired.
    c. Provide an auditory clue related to the skill desired.

13. Unit approach: organizing varied learning activities or experiences around an interest or theme, and designing them to further developmental learning or tasks.

    a. Base the unit on real-life experiences.
    b. Direct the unit to student level of development.
    c. Try to provide for the acquisition of attitudes as well as for the attainment of skills.
    d. Bring purpose into much of the student involvement and leisure activity.

14. Chaining: progressing step-by-step from easy-to-learn steps to a final complex behavior comprised of the simple steps. Frequently used to instruct in a new and complex behavior. Each unit of behavior is likened to a link in a behavioral chain that leads to the completed behavior.

    a. Backward chaining mode: teach the student the last step in the behavioral chain, thus completing the task and providing opportunities for a high frequency of reinforcement.

b. Forward chaining mode: teach the smallest, beginning increment of the task with reinforcement either for completion or successive approximations of the desired linked behavior.

15. Graduated guidance: analyzing and presenting the skill to be taught in a sequential manner. The student should possess some of the skills necessary to perform the full task. Each behavior in the sequence establishes readiness for the occurrence of the next behavior on a graduated teaching/learning spiral.

    a. Define each skill experientially and behaviorally.
    b. "Slice back" unachieved behaviors as an integral part of this process.

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SAMPLE

I. Teaching Strategy Plan

From the IEP pull out the student's strengths and weaknesses, goals and objectives:

Student's Name: ____________________ ____________________

____

Needs help in:	First Strategy	Second Strategy	Third Strategy
Self Help			
Social/Emotional			
Communication			
Cognitive			
Gross Motor			
Fine Motor			
Sensory			

II. IEP Information (sample)

Goals: ____________________________________

Objectives: ____________________________________

Strengths and weaknesses: ________________________

III. Based on the above information, identify teaching strategies that would facilitate behavioral child change.

	Most appropriate	Utilized periodically	Not appropriate
1. Individual and Group Control			
2. On-Task Behavior			
3. Structuring Teaching/ Learning Situation			
4. Providing Mind-Set or Attention Procedure			
5. Task Analysis of Skill Content			
6. Experiential Based Strategies			
7. Concrete-Semi-Abstract-Abstract			
8. Modeling			
9. Behavior Modification			
10. Direct Instruction			
11. Visual/Auditory/ Kinesthetic			
12. Clueing			
13. Unit Approach			
14. Chaining			
15. Graduated Guidance			

SECTION SEVEN

RELATIONSHIP TO REGULAR EDUCATION

Part 1: INTRODUCTION

Public Law 94-142 requires that educational services for all handicapped children be delivered via programs that serve the individual needs of each handicapped child in the least restrictive environment. Integrating or mainstreaming this population into the school is a delicate process and, for success, must be done with the welfare and comfort of all students, staff, faculty, parents, and the community in mind. Careful planning is essential; thoughtful and thorough preparation, preferably before the entry of the child, may make the difference between success or failure in integrating the severely and profoundly handicapped child into the public schools. Success has been documented in programs where concerned parties, particularly the regular education faculty and staff, students and parents of those students, are gradually sensitized to those qualities, characteristics and needs that severely, profoundly handicapped children share with all children. Meeting children with less severe and obvious problems, and gradually being introduced to those with more profound disabilities, gives teachers and students who are unfamiliar with such problems an opportunity to adjust successfully to them.

Normal peer advocacy has been very successful where structured, intentional methods prepare children in regular classes to fill this role. Bringing the normal child into the severely, profoundly handicapped classroom and taking the severely, profoundly handicapped child into the auditorium, lunchroom, playground, and other areas with the normal peer advocate can advance the learning of both children immeasurably.

As severely or profoundly retarded students enter the public school environment, staff can structure a number of ways in which they can be integrated with their peers.

Some potential interactions in activities may include:

1. Playground
2. Lunchroom
3. School assemblies
4. Physical education
5. Curricular involvement
6. Peer tutoring
7. Musical activities
8. Art activities
9. Library
10. Informal contacts before and after school, in halls

One example of integration is the Project CHAIN classroom:

> The classroom is housed in a regular elementary school. Although neither the school nor the district has any administrative responsibility for the classroom, every effort has been made to ensure that the classroom will function as a part of the school. The CHAIN children eat in the school cafeteria and are eligible to apply for free lunches on the same basis as other students. The school nurse has copies of the children's relevant medical records and will provide care for an ill child. The CHAIN teacher participates in the regular faculty meetings of the school.
>
> The principal and the other teachers in the school have been cooperative in providing opportunities for interaction and integration of CHAIN students with the regular class students. As previously noted, the children participate in the school lunch program, eating in the school's cafeteria. Use of the primary playground provides opportunities for social interaction with students from the regular classes and the other special education classes in the school. Regular class teachers provide time for selected students to be involved in CHAIN classroom activities. Younger elementary students participate in free play activities. Older students are trained to serve as tutors for individual program activities. There is a Headstart program in the school, and one child from CHAIN is integrated into Headstart for part of each school day. Goals and objectives for this participation in the Headstart class have been jointly established by Headstart staff

and the CHAIN teacher. This is considered to be critical physical association. A checksheet has been developed to allow Headstart teachers to provide, on a weekly basis, information to the CHAIN classroom teacher concerning the child's progress toward the objectives.

The following specific ideas and successful techniques have been used to facilitate acceptance of severely handicapped students in the school:

Assess individual needs before planning events.

Hold extensive inservice training sessions--preferably before the children enter school.

Schedule handicapped persons who are interesting speakers to present to faculty and students.

Show films of handicapped people functioning in society.

Involve advocates of the handicapped as participants in activities, such as simulations.

Utilize films or speakers dealing with behavioral techniques.

Train staff for medical and other emergency situations.

Show existing model programs through slides, films or videotapes.

Use special education personnel to inservice train regular educators.

Provide structured group interaction possibilities and include custodians, bus drivers, food service staff, aides and parents, as well as regular and special educators.

Establish special meeting times because regular faculty meeting schedules are usually full.

Feature programs on the multiply handicapped at PTA meetings.

Encourage staff members and students to visit classrooms for the severely handicapped in other facilities.

Arrange time for special education teachers to visit other exemplary programs.

Sponsor a sixth-grade class project where the students and teacher prepare a videotape of the special class to be shown to all other students and faculty in the school.

Initiate a student tutor program (tutors gain experience in helping others, serve as models and advocates for the handicapped students--while improving their own skills and increaing their own feelings of capability and self-worth).

Be sure special education staff participate as full faculty members, sharing responsibilities in administration, participating in all faculty affairs, and developing good one-to-one relationships with regular staff. (Special educators have a critical role in gaining acceptance for their students.)

Organize aides to accompany severely handicapped students when they leave the self-contained classroom to participate in other classes; the aide or other assistant can assist the receiving teacher in serving the student.

Prepare special education teacher to cooperate in providing means of testing the child's competency in other classes.

Several factors emerge as most critical in supporting the special education-regular education relationships which must underlie successful integration of handicapped students into appropriate mainstream activities:

1. A principal who is committed to and supportive of the program;
2. Ongoing public relations and education of significant others in the school and community;
3. Planned training of regular educators and regular classroom students;
4. A faculty and staff well trained in behavioral management techniques and in coping confidently with medical and emergency situations;
5. Special education faculty and staff who build strong, cordial, cooperative relationships with other faculty and staff.

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SAMPLE

STUDENT PLACEMENT FORM

(May be used to track integration progress of four children, or as a long-term record for one child. Add details of placement and dates in columns.)

Student Names				
Level One: Service outside public schools				
Level Two: Self-contained within the public schools				
Level Three: Participation in a. Food service b. Extracurricular activities c. School functions d. Physical education facilities e. Other				
Level Four:* Participation in a. Curriculum and education programs with peer tutors b. Curriculum and educational programming with population of public school c. Other				
Level Five:* a. Complete integration in regular education in public school b. Complete integration in regular education in neighborhood school c. Other				

*Regular education personnel potentially involved in IEP.

SECTION EIGHT

LEARNING ENVIRONMENT SPACE DESIGN

Included in learning environment considerations are three general areas: accessibility to programs, physical mobility within programs, and general aesthetics--is the classroom intentionally conducive to learning through design and decor. Access by the handicapped to school programs, including areas of assembly, is mandated by law. Local school districts must examine facilities and devise ways to make programs available to the student or to structurally modify the facility to enable the student to move into activities with other students. Whatever means are used to guarantee accessibility must insure that the student is not segregated, but integrated into the nonhandicapped student body.

Once programs are accessible, the resourceful professional must know where to get adaptive equipment to facilitate the mobility and the training of the severely handicapped student. Synthesis of a new piece of adaptive equipment could be instrumental in meeting a particular need. Individuals who are concerned with the child's progress (e.g., the teacher, physical therapist, audiologist, etc.) might collaborate in synthesizing the needed equipment. Analysis of the student's needs by several resourceful professionals will probably produce some creative solutions.

Beyond student accessibility, mobility, and positioning for learning, the teacher is concerned with the attractiveness and stimulation of a functional classroom design. The decor can be enhanced, for example, by the use of materials that relate to the curriculum--commercially prepared materials, materials from community sources, teacher-made materials, and especially, those materials or products that the students can make and enjoy as their share in enhancing the classroom environment.

Classrooms for all children should provide a conducive environment for learning; they should provide adequate space for the children, the teacher and aides; they should be arranged to facilitate use of the equipment, supplies and materials that will be utilized by the teaching team and students. When the classroom houses severely handicapped students, meeting these needs challenges the administrative skills of those who are responsible for providing the physical and environmental setting for students. Each classroom should be viewed as part of the total school building, moreover, and should encourage the easy interaction and integration of the handicapped student with his or her nonhandicapped peers. Such interaction will depend on more than the physical layout of the classroom, however; it will also depend on acceptance of the seriously impaired students by other faculty members, paraprofessionals, and the other students enrolled at the school.

One classroom for the severely handicapped is the model program developed in Arizona and known as Project CHAIN.

Project CHAIN's classroom program has been reorganized; as part of that reorganization, the physical classroom was changed. Previously partitioned into many small areas for one-to-one teaching without distraction, the room has been "opened" to allow for ease of movement by the children. Dividers and storage cabinets were moved to the walls. The teacher's desk and file cabinet were moved into a corner of the observation booth where they took up little space. This opened the center of the room and allowed for the following:

- Easy movement of children from group to group (especially important for children in cumbersome equipment or for the lifting of very heavy children).
- Supervision from one vantage point.
- Large space available for physical therapy activities such as walking or crawling, rolling children over physical therapy ball, or work with barrel.
- Children positioned for physical therapy (side lyers, etc.) are aware of and involved in other activities around them, opening up an awareness of environment.

Children in individual instructional settings are removed to the observation room or to a corner of the room away from the main activity.

Two pieces of equipment were obtained by Project CHAIN which are of particular import. One, a waterbed, provides sensory input to very severely involved children for whom programming is generally very difficult. The waterbed is also quite useful for prewalking activities and training balancing skills. Apart from all of that, it is a peaceful place for a teacher to lie down with all of her children and share a quiet moment, or have a storm at sea. The second piece of equipment is quite simple: a set of screw-in eyes, a cable and several hooks from which to hang mobiles, etc. The cable is stretched across the room semidiagonally and has room for many hanging objects (mobiles, etc.) which can be shifted to any location along that line. (See figure 1, page 8-6).

Classroom Considerations.[1]

I. General Physical Design Considerations.

- A. Facility must be generally barrier-free.
  1. Ground floor, if possible.
  2. Wheelchair ramps with railings; doorways to accommodate wheelchairs.
  3. Handrails in hallways and bathrooms.
  4. Toilets, sinks, drinking fountains accessible to students.
- B. Physical space and classroom layout.
  1. Classroom size recommended: 900 sq. ft. for a maximum of 15 children.
  2. Movable partitions, shelves or cabinets to provide space for various size groups and instructional purposes.
  3. Additional space recommended:
     - a. partitioned observation and/or individual tutoring area.
     - b. bathroom and changing room.
     - c. office space for teacher and therapists.
- C. Air conditioning and ventilation.
  1. Temperature control.
  2. Extra exhaust fans to aid ventilation.
- D. Lighting.
  1. Natural light from windows.
  2. Artificial lighting, rheostat-controlled.
- E. Flooring.
  1. Carpeted areas.
     - a. physical therapy.
     - b. training areas.
     - c. small group and individual instruction areas.
  2. Tiled areas.
     - a. room entrance and a way through the room for wheelchairs.
     - b. bathroom and changing area.

---

[1] Information in Parts I, II and III is from Administrators Resource Manual for the Deinstitutionalization of Children and Youth, 1979.

Project CHAIN classroom.

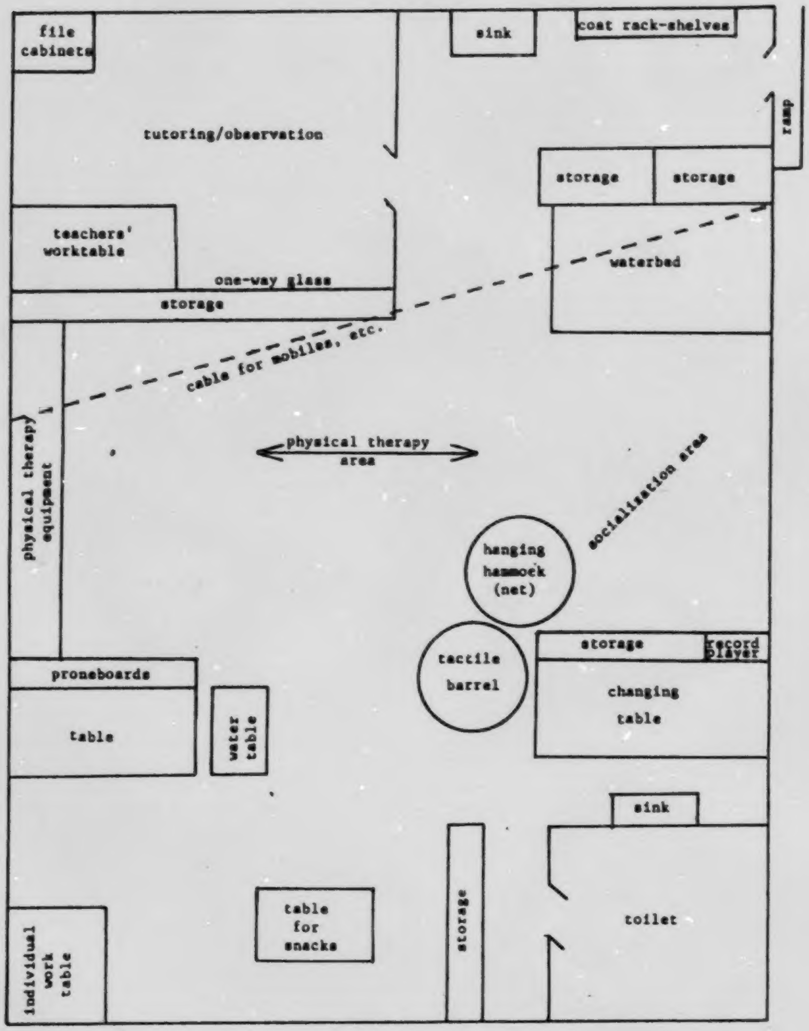
file cabinets
sink
coat rack-shelves
ramp
tutoring/observation
storage
storage
teachers' worktable
one-way glass
waterbed
storage
cable for mobiles, etc.
physical therapy equipment
physical therapy area
socialization area
hanging hammock (net)
tactile barrel
storage
record player
changing table
proneboards
table
water table
sink
table for snacks
storage
toilet
individual work table

Fig. 1.

II. Furniture and Equipment.

  A. Physical/occupational therapy (e.g. mats, wedges, prone boards, side lyers, floor sitters).

  B. Speech/language and communication devices; adaptive feeding equipment.

  C. Storage cupboards, closets, shelves.

  D. Tables and chairs, child and adult size.

  E. Classroom supplies and materials.

  F. Appliances.
    1. Washer/dryer (if laundry service is not used).
    2. Refrigerator, for snacks, juice, etc.

  G. Audio-visual equipment.

III. Special Problems to be Considered.

  A. Cleaning and maintenance: extra personnel and supplies may be needed.

  B. Laundry needs.
    1. Towels and washcloths.
    2. Disposable diapers.

  C. Room odor--prevention by:
    1. Toilet training.
    2. Frequent checks and diaper changing.
    3. Adequate ventilation and exhaust fans.
    4. Air deodorizers.

IV. Sensory Integration Considerations (Decor).

  A. Colorfulness.

  B. Current with season, holiday.

  C. Appropriate for interest and age levels of children.

  D. Related to curriculum goals.

  E. Motivational decorating changes made.

V. Buildings and Grounds[2]

  A. Modify doors for ease of opening.

---

[2] Parts V, VI and VII are from Harrison and Johnson, Establishing Services for the Severely Handicapped in Public Schools, 1975.

B. Install locks so that danger areas are inaccessible to the handicapped child. (Such areas may be inside or outside the building.)

C. Eliminate unneeded doors.

D. Provide ramps between different floor levels inside and outside of buildings.

E. Eliminate sharp wall corners and potentially hazardous protruding objects on walks and floors.

F. Adjust lighting to assure that illumination will reach all areas; e.g., more light may be required if the student works on the floor rather than on the table top.

G. Establish the shortest fire exit routes.

H. Place handrails and supports in appropriate places.

I. Adjust toilet and sink heights to make them accessible for independent student use.

J. Provide clean-up room for washing and reclothing students following bladder and bowel accidents.

K. Provide a hoist for lifting nonambulatory students for:
   1. Movement during instruction.
   2. Movement to toilet.
   3. Pool therapy.
   4. Physical therapy.

L. Provide a place with appropriate furnishings to facilitate the removal and replacement of braces.

M. Provide recreational areas inside and outside the building that provide room for:
   1. Self-initiated movement for the child.
   2. Movement for all children in or out of wheelchairs.
   3. A variety of stimulating experiences.

N. Provide a student lounge.

O. Visit other schools that have adapted facilities for the handicapped, and utilize their good ideas.

P. Make as many adaptations as the budget will allow.

Q. Keep a file of future adaptations so you will be prepared to request them at the appropriate time.

VI. Communication

A. Obtain a copy of the Participant Resource Book listed in Part 3: Selected Bibliography. This describes many communication alternatives: typewriter, Bliss symbols, ETRAN, conversation board, radial pointer, rotating arrow scanner, Roto-com, Slip 'N Slide, System 8, TIC porta-printer, light writer, portable autocom, Possum expanded keyboard, and MC 6400.

B. List communication alternatives that you are now using for:
   1. Deaf.
   2. Deaf-blind.
   3. Nonverbal cerebral palsied.
   4. Nonverbal retarded.
   5. Others who cannot use expressive or receptive language.

C. List unfulfilled communication needs for the same groups.

D. Make arrangements for acquiring needed devices:
   1. Order commercially.
   2. Request construction from the school district.

VII. Ambulation and Position

A. Assess the needs of nonambulatory students:
   1. To position for learning.
   2. To strengthen lungs and muscles.
   3. To encourage independent movement.
   4. To control involuntary movement.
   5. To prevent astrophy.

B. Obtain Mobilizing Multiply Handicapped Children and ISAARE for information on possible equipment and modifications (see Part 3: Selected Bibliography).

C. Select equipment to be adapted for student movement:
   1. Wheelchairs.
   2. Walkers.
   3. Canes.
   4. Crutches.
   5. Parallel bars.

D. Select equipment for adaptation to allow positioning student for instruction and stimulation:
   1. Lap boards.
   2. Wheelchairs.
   3. Standing tables.
   4. Reclining chairs.

E. Measure students to determine equipment adaptation.

F. Make arrangements for acquiring needed adapted equipment:
   1. Order commercially.
   2. Request that the school district construct or adapt.

G. Assess the effectiveness of the adaptation after the student has utilized the equipment.

H. Remodify if necessary.

VIII. List of Materials and Equipment Used in the Project CHAIN demonstration classroom.

- prone boards
- adapted scooter board
- corner chair
- adapted toddler chair
- Mancino Developmental Crawler
- Mancino Learning System Chair
- mats
- barrel
- walker
- bean bag chair
- wedges
- vestibular board
- spot trainer
- record player and records
- communication board (pictures)
- large beach balls
- rhythm band
- mobiles and cradle gyms
- activity center busy box
- tops, pound-a-round
- balls
- pegboard
- teethers
- rattles
- rubber squeak toys
- paint
- crayons
- marking pens
- picture books
- easel (table top)
- tactile stimulation box
- sand/water table
- water toys
- mirrors
- noninterlocking puzzles
- bells
- flashlight, penlight
- vibrators (battery)
- dolls
- refrigerator
- pull toys
- wind-up toys
- hand puppets
- disposable diapers
- adaptive feeding equipment
- wading pool
- side lyer
- individual and group tables
- file cabinet
- closed storage cabinet
- linen (wash cloths, towels)
- rocking boat
- battery charger
- sandbags
- bolsters and rolls
- paint aprons
- prone board straps
- tumble-back toys
- blocks (wood and plastic)
- bristle blocks
- pounding toys
- large-size clothing
- net hammock/swing
- baby food
- teething biscuits

Administrators resource manual for the deinstitutionalization of children and youth. Salt Lake City: Southwest Regional Resource Center, University of Utah, 1979. (Will be available from ERIC.)

Aino, E. A., and Loversidge, R. D. Jr. (Eds.) Access for all: An illustrated handbook of barrier-free design. Columbus. Special Press, 724 Roosevelt, Columbus, Ohio 43209, 1979, $25.50 postpaid.

Brown, L., et al. Madison's alternative for zero exclusion: Papers and programs related to public school services for secondary age severely handicapped students. Madison, Wisconsin: Madison Public Schools, Department of Specialized Educational Services, 1976.

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Suggested guidelines for local school district compliance with section 504 of the Vocational Rehabilitation Act of 1973. Phoenix: Arizona Department of Education, 1978.

Vanderheiden, G. C. Nonvocal communication techniques and aids for the severely physically handicapped. Gregg C. Vanderheiden, 233 E. Redwood Street, Baltimore, Maryland 21202, $12.50.

Resources/Catalogs for Special Equipment and Furniture

Abbey Rents and Sells
724 W. Indian School Road
Phoenix, Arizona 85013
(602) 277-5744

"Achievement Products for Children"
Achievement Products, Inc.
P. O. Box 547
Mineloa, New York 11501
(516) 747-8899

Community Playthings
Rifton, New York 12471
(914) 658-3142

"Preston Special Education Materials"
J. A. Preston Corporation
71 Fifth Avenue
New York, New York 10003
(800) 221-2425

"Be OK Self-Help Aids"
Fred Sammons, Inc.
Box 32
Brookfield, Illinois 60513
(312) 246-3216

"S. D. E. Equipment for Children and Adults"
Skill Development Equipment Co.
Box 6300
1340 North Jefferson
Anaheim, California 92807
(714) 524-8750

Western Medical Supply Company
2040 N. 16th Street
Phoenix, Arizona 85006
(602) 257-9347

Resources/Catalogs for Classroom Supplies and Materials for Special Education

"Toys That Teach," "The Growing Years Catalog," "For Children With Special Needs"
Childcraft Education Corporation
20 Kilmer Road
Edison, New Jersey 08117
(800) 631-5657

Constructive Playthings
12373 Garden Grove Blvd.
Garden Grove, California 92643
(714) 636-7831

Developmental Learning Materials
7440 Natchez Avenue
Niles, Illinois 60648
(312) 647-7800

Educational Teaching Aids
159 W. Kinzie Street
Chicago, Illinois 60610

"Catalog of Play, Learning and Growth"
Kaplan School Supply Corporation
600 Jamestown Road
Winston-Salem, North Carolina 27103

Lakeshore Curriculum Materials Co.
16463 Phoebe St.
La Mirada, California 90637
(213) 921-7468

"Nasco Learning Fun"
NASCP
P. O. Box 3837
1524 Princeton Avenue
Modesto, California 95352

Teaching Resources Corporation
100 Boylston Street
Boston, Massachusetts 01226

Teaching Tools
P. O. Box 27567
Phoenix, Arizona 85061
(602) 272-7973

SAMPLE

Checklist of Environmental Needs

Student Name: ______________________

Date: ______________________

Teacher: ______________________

Architectural Needs	✓	Classroom Needs	✓	Adaptive Equipment Needs	✓
Ramps		Movable partitions		Physical/occupational therapy (mats, wedges)	
Handrails		Individual scooter board		Speech/language devices	
Accessibility to: Toilet Fountain Sinks Wheelchair accommodations		Carpeted floor area		Adaptive feeding equipment	
Etc.		Natural lighting		Storage cupboards	
		Individual instructional area		Adaptable tables and chairs	
		Tile floor area		Audio visual equipment	
		Etc.		Adaptive manipulation equipment	
				Etc.	

SECTION NINE

LINKAGES WITH THE RESIDENTIAL SETTING

Cooperation and coordination between the school and the residential environment of severely or profoundly handicapped students are essential to the success of the educational program. The mastery of self-help skills, language, speech, mobility, and other basic skills depends highly on consistency and continuity. To assure consistency and continuity, a system of ongoing communication must be established so that the child can attain the goals set for him/her. The parents or responsible adults are basic to both the planning and execution of the educational plan.

Both Arizona State laws and PL 94-142 require prior notice to parents, informed parental consent, and active parent participation at specific points in the delivery of educational services to a handicapped student. Administrators must identify who is authorized to serve as the parent for students who have been institutionalized; once a determination has been made, the authorized person will participate in the educational decision-making process at the same points that a natural parent would.

To facilitate communication on the progress of the student after the objectives of the IEP have been agreed upon, it is recommended that a communications notebook be developed for each child to send back and forth between the school and the residential setting (home, foster home, group home, etc.). The notebook could be used to document progress/problems on a day-to-day basis.

In addition to or as an expansion of the concept of a communication notebook, a program involving continuous training and daily exchange of information might be developed, such as teacher-parent programming. (Note that the "parent" might be the group home parent, foster parent, or other person designated to play the role of parent.) Counseling might facilitate relationships between teacher and parent as well as better serving the needs of both. Supporting parent-to-parent groups strengthens relationships between the school and the residence and is consistent with providing appropriate services for children.[1]

Teacher-Parent Programming: The following steps can help develop a cooperative relationship between parents and teachers that will benefit the handicapped child:

1. With parents and others formulate the IEP.
2. With parents, select goals and write the instructional program for home and school. Select some goals that are high priorities for the parents.
3. With parents, establish ways of measuring, recording, and reinforcing goals.
4. Initiate selected programs; use a notebook or other data collection device to transfer information between residence and school.
5. Schedule appointments for progress reports. Invite parents to call as needs arise.
6. Meet again with parents to review the data, determine if goals have been met, and continue or establish new goals.
7. Start at step 2 and continue.

Parent Counseling:

1. Hire or name a parent-and-child-guidance counselor for parents of the severely handicapped students in your program. The counselor could be:
    a. professional within school staff (teacher, principal, curriculum coordinator, social worker, etc.);
    b. county mental health worker;
    c. social service counselor;
    d. counselor from other country or state agency.

---

[1] The following information was adapted from Harrison and Johnson, op. cit.

2. Arrange for counselor to meet with faculty of school explaining his/her availability and the procedures to follow in making appointments, etc.

3. Notify parents of services of the counselor:

    a. teacher explains counseling service to parents during parent-teacher conferences.
    b. newsletter, containing an article written by the counselor on different ways parents might be counseled, is sent to all parents.
    c. counselor speaks at P.T.A. meetings and parent-to-parent groups.

4. Inform parents of new students of services available.

5. Set up appointment procedures:

    a. normal.
    b. crisis.

6. Parent-and-child-guidance counselor can:

    a. suggest ways a parent may change behavior of the handicapped child.
    b. be available during a crisis.
    c. be a facilitator in the parent-child adjustment process.
    d. be a liaison among the parent, the teacher, and the school.

Parent-to-Parent Group: Parents talking with one another about their handicapped children can be an effective force in the development of positive parent-child adjustments. Following are some suggestions on how to organize a parent-to-parent group:

1. Select a person or group to take the lead in the formation of the parent-to-parent group.

2. Leadership group or person plans objectives and agenda and makes assignments for the first parent-to-parent group meeting, which will be an organizational meeting.

3. Leadership group completes assignments for organizational meeting:

    a. duplication of notices and invitations.
    b. invitation to parents.
    c. refreshments.
    d. recruitment of baby sitters.
    e. organization of car pools.

4. Hold parent-to-parent organizational meeting. (See SAMPLE FORMS)

5. Suggested outcomes of first parent-to-parent meeting are:

    a. purpose of group.
    b. future meeting dates.
    c. group leader.
    d. topics for future meetings.

6. Contact agencies that are equipped to assist parents of handicapped children.

    Example: The Bureau of Education for the Handicapped funds "Closer Look," an important agency that responds to requests from parents, professionals, and others about organizing and maintaining parent groups. "Closer Look" offers the following kinds of information without charge:

    a. practical advice to parents: information on finding services for handicapped children.
    b. parent information packet: information designed for the needs of handicapped children and young adults, description of parent organizations, and reading lists.
    c. rights information: explanation of state laws and lists of public education facilities for the handicapped student.
    d. report from "Closer Look": information for parents on events in the world of the handicapped; sent periodically to all users of the information service. Send all inquiries to: "Closer Look," Box 1492, Washington, D. C. 20013.

Part 3: SELECTED BIBLIOGRAPHY

Baldwin, V. L., Fredericks, H. D. B., and Bordsky, B. *Isn't it time he outgrew this? or A training program for parents of retarded children*. Springfield, Illinois: Charles C. Thomas, 1973.

Blumberg, A. *The training of parents of profoundly and severely mentally retarded children in handling behavior at home*. Vitro: West Virginia University, Kanawha Valley Graduate Center, 1971.

Cook, C. (Ed.) *Diagnostic and prescriptive programming for the severely handicapped*. Eugene: Northwest Special Education Learning Resource System, University of Oregon, 1974.

Esche, J., and Griffin, C. *A handbook for parents of deaf-blind children*. Lansing: Michigan School for the Blind, Spring 1969.

Fredericks, H. D. Bud, et al. *A data based classroom for the moderately and severely handicapped*. Springfield, Illinois: Charles C. Thomas, 1976.

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Hatton, D. A. *Understanding cerebral palsy, a handbook for parents*. Erie, Pennsylvania: Erie County Crippled Children's Society, 1967.

Losen, S. M., amd Diament, B. *Parent conferences in the schools*. Boston: Allyn & Bacon, 1978.

McCormack, J. E., and Audette, R. H. Developing twenty-four hour service plans for severely handicapped learners, *AAESPH Reviews*, Vol 2. No. 4, December 1977, pp. 209-216.

Penucci, J., Hines, M., and James, C. Eating with a spoon . . . How to teach your multi-handicapped child. Columbus: Ohio State University, 1975.

Pfleuger, S. S. Independent living. Emerging issues in rehabilitation. Washington, D. C.: Institute for Research Utilization, Washington Transportation Alliance, December 1977.

Pots and pans activities for parent and child. Chicago: Office of the Superintendent of Public Instruction, Department of Exceptional Children, Instructional Materials Center.

Sandow, S., and Clarke, A. D. B. Home intervention with parents of severely subnormal, pre-school children: An interim report. Child: Care, Health & Development, Vol. 4, No. 1, January/February 1978, pp. 29-39.

Schumaker, J., Horell, N., and Sherman, J. A home-based school achievement system, in Managing behavior, Part 9. Lawrence, Kansas: H & H Enterprises, Inc., 1975.

Wehman, P. H. The role of different environmental conditions on leisure time activity of the severely developmentally disabled. Madison: University of Wisconsin-Madison, 1976.

Delegation of these responsibilities is subject to the identification of appropriate personnel within each school district.

SAMPLE

COORDINATION PLAN FOR HOME/SCHOOL INTERACTION

PROCEDURES	ACTIVITIES	IMPLEMENTATION	
		Date	Person* Responsible
1. Parent and responsible person training sessions	1. Identify needs 2. Identify available training material on needs 3. Plan presentation 4. Conduct presentation 5. Evaluate and follow-up		
2. Home-based instruction	1. Select home-based curriculum on identified student needs 2. Initiate home-based curriculum with parent 3. Demonstrate home-based activity 4. Develop procedures for parent involvement 5. Evaluate and provide technical assistance to parent		
3. School-to-home recording method--instructional and achievement	1. Select or develop a device for school-to-home-to-school information on instructional goals and achievement 2. Initiate the home recording system with parent 3. Provide technical assistance on implementation 4. Conduct parent-school interaction 5. Evaluate and follow-up		

*Title or name, as appropriate

PROCEDURE	ACTIVITIES	IMPLEMENTATION	
		Date	Person Responsible
4. Parent/responsible person volunteer program	1. Parent meeting to explain program, scheduling, participants, etc. 2. Provide training for parent volunteer involvement 3. Conduct periodic seminars 4. Develop teaming approaches 5. Evaluate		
5. Parent-parent group	1. Conduct meeting to explain parent-to-parent linkage 2. Identify persons as parent-parent teams 3. Provide communication process 4. Facilitate parent-parent linkage meeting 5. Evaluate and provide technical assistance		
6. Home instruction packets for parents	1. Select or develop home instruction packets to coordinate with curriculum 2. Conduct a meeting to initiate packet use 3. Develop a communication procedure for interaction 4. Facilitate a student monitoring system 5. Evaluate packets and procedures		
7. Other	1. 2. 3. 4. 5.		

SAMPLE

ESTABLISHING A PARENT-TO-PARENT GROUP[2]

Example: Objectives and strategies for first parent-to-parent group.

Objective: Parents of school children will attend parent-to-parent meeting on March 4, 19__ to decide on future agenda items and outcomes for the parent-to-parent group.

Strategy	Who	When
Invitation to parents	Leader of parent group	February 3
Each parent invited during parent conference	Principal informs all teachers to invite	February 25
Each parent given a written invitation	Made by child; teachers give invitation	At February 25 conference
Each parent called	Room mothers	Week of March 1
Duplication of notice	Coordinator	March 2
Second notice sent home	Written by teacher A; sent by all teachers	March 3
Baby sitters made available	Teacher B	Ready March 4
Car pools organized	Teacher C	Ready March 4
Refreshments	Teacher D	Ready March 4
Meeting conducted	Leader	March 4

---

[2] Harrison and Johnson, ibid.

APPENDIX A

SPECIAL CONCERNS: MEDICAL

Part 1: INTRODUCTION

The physical involvement that is part of the profile of the severely and profoundly handicapped child is a basic consideration in planning the child's educational program. When the physical and medical assessment information is received by the school, the educational team must plan an IEP that includes ways of dealing with the child's physical impairments.

The medical problems of the severely and profoundly handicapped may be awesome to the classroom teacher and other regular education personnel or others not familiar with this population. With training, the teacher and other professionals and paraprofessionals can become acquainted with techniques and procedures for dealing with medical problems and emergencies.

The following suggestions are from Project CHAIN:

> With severely multiply handicapped children, account must be taken of the fact that some of the children may be subject to medical crises. The school nurse must be informed of kinds of crises which may arise. In addition, preliminary arrangements must be made, such as signed permission from parents, to transport children immediately to the nearest hospital. This is not generally permitted for schools and must be cleared in advance by parental signature.
>
> Classroom staff should be trained by the physical therapist to do postural drainage with percussion and vibration. In addition, if there is any likelihood that it might be needed, suction equipment should be available and classroom staff trained in its use. School nurses are often responsible for more than one school and might not be available in an emergency.

Policies and procedures of the district should be clearly outlined and available to the staff.

Part 2: OTHER CONSIDERATIONS

Pertinent Questions

Have relevant medical records been transferred to school?

Immunizations?

Medications?

Allergies?

Possible emergency situations and treatment, especially as associated with syndromes and other medical conditions?

Others?

Have results of medical and physical assessments been utilized in writing the student's IEP (e.g., positioning needs, rest requirements, strength and stamina, control of seizures, etc.)?

What special medical equipment needs are indicated?

Oxygen?

Colostomy?

Catheterization?

Other?

What are sources for this equipment?

What procedures have been set up to deal with medications?

Written records of protocol?

Directions for dosage, monitoring?

Storage, equipment for storage?

State regulations?

Forms?

What training is available for staff in meeting medical needs, especially with more complicated procedures?

CPR (cardiac pulmonary resuscitation)?

Heimlich Maneuver?

Colostomy?

Catheterization?

Other?

Is there a crisis model for dealing with emergencies?

Procedures?

Persons to inform: medical staff, parents, group home, hospital, etc.?

Forms?

Emergency numbers?

Are district policies clearly outlined and available?

Did you follow the policies and procedures of your school district?

Part 3: SELECTED BIBLIOGRAPHY

Edgar, E. Development of individual education programs, in Haring, N. G., ed., *Developing effective individualized education programs for severely handicapped children and youth*. Columbus: Special Press, 724 Roosevelt, Columbus, Ohio 43209, 1977, $11.45 postpaid.

Epilepsy school alert. Washington, D. C.: Epilepsy Foundation of America, 1828 L Street, N. W., Washington, D. C. 20036 or local chapter of Epilepsy Association.

Holland, V. F., and Rubeck, R. F. (Eds.) *Operating manual for residential services personnel*. Columbus, Ohio: Nisonger Center for Mental Retardation and Developmental Disabilities, 1974.

Managing medical problems in the classroom, from SECRETS: The training program for teachers of the severely/profoundly handicapped. Module VI: Medical management. 16 mm film produced by Education Service Center, Region XIII, Austin, Texas.

Project MAZE: A dialogue on specific medical and health concepts of severely and profoundly handicapped students. Madison Public Schools, Wisconsin, 1976.

SAMPLE

ADMINISTERING MEDICINES TO STUDENTS

ROOSEVELT SCHOOL DISTRICT NO. 66
6000 South 7th Street
Phoenix, Arizona 85040

Date__________________

__________________________School

REQUEST FOR GIVING MEDICATION AT SCHOOL

Name________________________________ Grade________________

Teacher_____________________________ School________________

Medication____

Time to be given_______a.m. Time to be given_______p.m.

Date from______________________to________________________________

I hereby authorize______________________, ______________________
(Name) (Position)

to be my agent to give the above named medication to my child,

__________________________________, as ordered by Doctor___________
(Child's Name)

__________________________________.

☐ This is a prescription which will be furnished by the parent or guardian and is labeled in an original prescription bottle with student's name, name of medication, amount to be given, time of the day to be given, and duration of treatment.

☐ This is a patent or proprietary medication furnished by the parent or guardian and the medication is provided in the original container.

____ ______________________
Parent or Guardian's Signature Date

____ ______________________
Address Phone number

____ ______________________
Physician's Signature Phone number Date

____
Principal

SAMPLE FORM

FOR CUMULATIVE FOLDER[1]

Name: ______________________________

birthdate: ______________________________

social security number: ______________________________

Parent or Guardian: ______________________________

telephone number: ______________________________

Doctor: ______________________________

telephone number ______________________________

Hospital: ______________________________

telephone number: ______________________________

Information for Hospital Admission: ______________________________

insurance type and number: ______________________________

____

____

Medicine: ______________________________

amount taken: ______________________________

time of day to be taken: ______________________________

Allergies: ______________________________

____

Special habits: ______________________________

____

---

[1] From *Operating Manual for Residential Services Personnel*, 1974. V. F. Holland and R. F. Rubeck, eds. Nisonger Center for Mental Retardation and Developmental Disabilities.

Sample, continued

Likes and Dislikes: ______________________________

____

Dietary Restrictions: ______________________________

____

Special Comments: ______________________________

____

____

____

____

Agency Contacts: ______________________________

Protective Services: ______________________________

telephone: ______________________________

Case Manager: ______________________________

telephone: ______________________________

Welfare Worker: ______________________________

telephone: ______________________________

Other: ______________________________

telephone: ______________________________

Religious Preference: ______________________________

APPENDIX B

SPECIAL CONCERNS: EMERGENCY RESOURCES

Part 1: INTRODUCTION

Emergency resources should be available for all students. With satisfactory emergency plans in place and personnel (including paramedics) thoroughly informed and trained, and with periodic review and drill, all concerned persons should be able to feel that emergencies can be handled expeditiously and professionally with the highest degree of comfort and safety for all children involved.

Fear can be avoided or greatly reduced through knowledge, training and learning to cope effectively with emergencies. Planning ahead is the key to dealing effectively and sensibly with emergencies. The staff must have basic emergency equipment on hand. The confident teacher will model competency and calm for students. Properly trained students also can be of assistance in emergencies.

Part 2: OTHER CONSIDERATIONS

Pertinent Questions

Do you have written procedures for action during emergencies?

Are these procedures posted in conspicuous places?

Are frequent, periodic reviews held to keep emergency services current?

Is the staff trained in techniques to use during seizures, choking, etc.?

Is a school nurse available full time?

Do the child's school records contain releases for emergency services?

In case of family crises, are there agencies to call for respite care, clothing, sitter, home care, nursing?

Does a fire plan exist for the special classroom?

What about evacuation procedures?

Are fire drills held?

Which staff need special training?

Special Considerations

Paramedics:

When a child is in acute distress (experiencing symptoms which may be life threatening) this procedure is to be followed:

1. Call for additional personnel.
2. Make child safe from self-injury.
3. Deploy one person to call paramedics.
4. After paramedics are called, telephone parents.

Prior to an emergency situation, invite the local paramedics unit to tour the facility housing high-risk children.

Provide emergency parking.

Clearly mark entrances to area where sick/injured will be found. Places near the nurse's office, etc., are suggested.

If the child is not in the usual health services area, a person should be sent outside of the building to direct the paramedics to the child.

Fire and Evacuation Procedures:

Schools in which special education classes are located should have Fire Plans already approved by the local fire department for the entire school. The existing plan and procedures should be reviewed and revised as necessary to take into account any special procedures required to safely evacuate handicapped children.

Many of the following elements will be a part of the school's current Fire and Evacuation Plan, while others may need to be added. The school administrator, special education teacher and chief of the local fire department should work together in planning and implementing special considerations based on particular needs of each student.

Elements of Fire and Evacuation Procedures:

I. Fire Plan

  A. Instruct all staff on what to do when fire or smoke is detected.

  B. List responsibilities of individual staff members.

II. Evacuation Plan

  A. Plan two exits for each room (one regular and one emergency).

  B. Diagram exits; post in a conspicuous place.

  C. Develop alarm codes; special codes may be used to denote location of the fire on the campus.

  D. Develop procedures for transporting students:

    1. Nonambulatory students: use of fire blankets, wheelchairs, special carries, or other devices.
    2. Ambulatory students: procedures to assure their safe and orderly exit from the building.
    3. Training of additional personnel needed to transport students.

E. Outline duties and responsibilities of person in charge of the evacuation.

F. Assign staff members in the school who are not directly responsible for classes (i.e. maintenance, cafeteria, office, nursing) to assist in evacuating special education classes. Outline duties and responsibilities in the plan.

III. Fire and Evacuation Drills

A. Conduct drills at least monthly.

B. Keep records on each drill.

1. Date and time.
2. Length of time it took to evacuate the area.
3. Response of students and staff (were procedures followed correctly?).
4. Recommendations for improvement.

IV. Staff Training

A. Designate one person to train staff in the Fire and Evacuation Plan and Procedures for the special education classes.

B. Hold training session at the beginning of each semester for all staff members involved in evacuation.

C. Require both a demonstration and a written test from every involved staff member.

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SAMPLE

EMERGENCY TELEPHONE NUMBERS[1]

Fire Station: ____________________

____

Police Department: ____________________

____

Ambulance: ____________________

Life Squad: ____________________

____

Poison Control Center: ____________________

____

Doctor: ____________________

____

Medical Society: ____________________

____

Area Hospitals: ____________________

____

____

Pharmacy: ____________________

Helpful Neighbors: ____________________

____

____

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[1] This and the following forms are from Operating Manual for Residential Services Personnel, 1974. V. F. Holland and R. F. Rubeck, eds. Nisonger Center for Mental Retardation and Developmental Disabilities.

SAMPLE

MEDICAL SERVICES AND HOSPITAL EMERGENCY RELEASE

I, the undersigned, authorize the ____________________________
(name of school)
to secure medical services as they appear to be needed or in case of any apparent medical emergency involving ________________________.
(name of student)

I also hereby agree to be completely responsible for any fees or charges necessitated by medical services, medications rendered to or prescribed for the above named. I further understand that the _____ _______________________________ will not be held responsible for medical
(name of school)
expenses incurred while the above named individual is participating in school programs.

In case of any apparent medical emergency, I, _________________ _____________________________________ bearing the relation of ______ __________________________ to _____________________________________ hereby give permission to the authorized physician in the hospital emergency room to perform the necessary treatment which will alleviate the emergency situation.

____
(Signature of parent or guardian)

(Witness)_________________________________(Date)____________________

SAMPLE

EMERGENCY PROCEDURES

I hereby give permission to ______________________________
(Name of school)
to initiate any/or all emergency procedures necessary for the health and safety of my child ______________________________
(Name)
during transportation to and from and during participation in the
____
(Name of school)
activities if I am not available to initiate the proceedings.

____
(Date) (Signature)

____
(Relationship)

SAMPLE

INFORMATION REQUIRED FOR HOSPITAL ADMISSIONS

1. Legal name of child ______________________________
2. Address ______________________________

   ____
3. Parent's name ______________________________

   Home Phone ______________________________
4. Date of birth of child ______________________________
5. Physician's name and address ______________________________

   ____
6. Father's place of employment ______________________________

   ____

   Phone ______________________________
7. Name of insurance company covering the child ______________

   ____
8. Blue Cross Number ______________________________

   Or Hospital Insurance Number ______________________________
9. Allergies ______________________________
10. Medication ______________________________

    ____

SAMPLE

MONTHLY FIRE DRILL SCHEDULE

A fire drill should be held at least once a month and recorded. Vary the time of day, location and exit plans. Specific comments on each drill should be recorded.

January

date____

time: begins____________ends________________

location______________________________________

comments______________________________________

____

____

February

date____

time: begins____________ends________________

location______________________________________

comments______________________________________

____

____

March

date____

time: begins____________ends________________

location______________________________________

comments______________________________________

____

____

____

APPENDIX C

SPECIAL CONCERNS: FEEDING

141

Feeding severely and profoundly handicapped children and youth presents several challenges. Educators and others helping these students at lunchtime and with snacks must expand their expertise to deal with concerns surrounding each individual's nutritional and developmental needs. Such concerns include:

1. What foods are necessary to provide the appropriate nutrients for optimal growth and development?
2. How should the foods be presented--temperature, texture and adaptive feeding techniques--to facilitate development of oral skills and to inhibit abnormal oral behaviors?
3. What adaptive devices could be utilized so that the child could gain a degree of independence by feeding himself?
4. How can possible later speech development be facilitated by teaching normal eating skills to enhance oral control?

Strategies for answering these questions require cooperation from everyone involved with the child, including teachers, parents, nutritionists and therapists.

Pertinent Questions

General Sanitary Considerations

What are the regulations concerning storage, preparation and serving of food in the school setting?

What are the requirements for special equipment and supplies needed to store, prepare or serve food?

What will be the sanitation procedures for the personnel, equipment and supplies as outlined in the above regulations?

Dietary Concerns

Does the child have any food allergies?

Is the child's diet nutritionally unbalanced because of food dislikes?

Do some of the child's medications cause certain nutrients to be discarded by the body rather than absorbed?

Can snacks and lunches at school be used to introduce new foods?

Would certain nutritional supplements be helpful for increasing calories or adding nutrients?

Does food preparation require special equipment in the classroom or lunchroom?

Can a child participate in the school lunch program by receiving free lunches, reduced payment or full payment?

Do quantities or types of fluids or foods consumed need to be recorded?

Presentation of Food

What position(s) will facilitate appropriate eating skills in the child?

What textures of foods are acceptable to the child and encourage appropriate eating skills?

What adaptive feeding techniques can the feeders use and where will they learn them? What equipment is needed?

What steps can be taken to ensure cooperation between the home and school in carrying out therapeutic feeding programs?

Acquisition of Self-Feeding Skills

What prerequisite oral and motor skills must the child have before he can learn to feed himself?

What specialized, adaptive feeding utensils and/or seating devices could be used by the child to assist him in feeding himself?

Eating and Oral Skill Development as Prerequisites to Later Speech Development

Has the speech pathologist reviewed the feeding program to make suggestions for incorporating sound production at eating times (especially snack time)?

Inservice Training Packet[1]

Feeding Techniques for the Handicapped

After reading this packet, you should be able to discuss the topics listed below. You will learn best if you carefully read the objectives and remember them as you read the text. Review them before you meet with the instructor. For this last review, remember that you have learned the necessary information if you can answer questions about the objectives listed below. If you have any questions, ask the instructor before you take the written examination.

The following is a list of questions you should be able to answer in your own words upon completion:

1. When should your hands be washed during feeding?
2. When should the client's face and hands be washed?
3. How do you test the temperature of the client's food?
4. How much fluid must a client receive at scheduled drink times?
5. When should you temporarily stop feeding a client during his meal?

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[1] Developed by the Bureau of Child Development, Arizona Department of Health Services

6. Why must clients with little physical control have a stable base for feeding?

7. Why is it important for the client to be positioned symmetrically?

8. Why is it important for the client to sit upright?

9. Why is it important for the client's feet to be positioned on a solid platform?

10. In what direction should the food be brought to the client's mouth?

11. Why should a client receive jaw control?

12. How is jaw control given to the client?

13. What precautions should you take in giving jaw control?

14. Why should a client receive "downward pressure on the tongue"?

15. How do you give "downward pressure on the tongue"?

16. Where should the table be positioned when a client is learning to self-feed?

17. When should a client be given assistance in self-feeding?

18. How should a client's affected arm be positioned during self-feeding?

19. How can you best assist a client if he needs a lot of help in self-feeding?

20. Why is it important to give the client minimal help when he is learning to self-feed?

21. If problems persist in a client's feeding program, who should you contact?

Feeding Techniques for the Handicapped

Objectives

Handicapped children and adults must eat for the same reason anyone does: to provide the body with the essentials for growth. Eating for many handicapped individuals is made difficult because of their abnormal movement problems and especially their lack of oral motor control. Many factors must be considered:

1. Overall health and hygiene
2. Body positioning
3. Movement of oral structures during the process of eating
4. Oral sensation

This packet will discuss normal patterns of eating, correct hygiene procedures, and some suggestions for the use of adaptive feeding techniques.

PART I: Health and Hygiene

Preparation before, during, and after eating is necessary to help prevent the spread of illness from one client to another as well as from the staff to the clients. In addition, there are accreditation, county, state, and federal health laws which list standards for the cleaning of clients, staff, tabletops, eating utensils, and other equipment.

Always wash the client's face and hands before feeding to prevent getting dirt or germs in his food, and after the meal to prevent food or liquid from drying on his skin. Always wash your own hands prior to feeding each client to prevent the spread of dirt or germs to the food or directly to the client. Be sure to wash your hands prior to feeding a second client so that germs cannot be transported from one client to another. Your hands must also be washed after feeding is completed.

You must avoid burning the client's mouth with food that is too hot for him. Test the temperature by stirring one compartment of food and drop a small amount of food from the spoon to the inside of your wrist. If the temperature of the food is uncomfortable to your wrist, it is definitely too hot for the client's mouth. Set the tray aside until the food has cooled.

It is very important that clients receive enough fluids into their system to prevent dehydration (loss of too much fluid from the body). At each meal time and other scheduled drink times, each client weighing under 30 pounds should receive at least six ounces of fluid.

Each client weighing over 30 pounds should receive a least eight ounces of fluid. If a client does not have good oral control and loses a lot of fluid while drinking, always be sure to make up for this loss of fluid by offering him more.

During mealtimes or scheduled drink times, there are two major health reasons for temporarily ceasing giving the client food or fluid. If he has a seizure, he may not be aware of food in his mouth and is in danger of aspirating (breathing the food into his lungs). When a client has a seizure, discontinue feeding him until the seizure is over. After the seizure, you may continue his meal if you feel he still wishes to eat. If a client vomits while eating, it is usually due to some health problem and he should be checked by medical personnel. Notify the nurse and do not continue the meal, unless you are instructed otherwise.

PART II: Correct Positioning

Correct positioning during feeding is more essential for clients with movement problems than for everyone else. If they do not have a stable, controlled base for sitting, it is difficult for them to control trunk, head, lips, cheeks, and tongue. In addition, if the head is in improper relationship to the body, the entire eating process of taking the food in, chewing, and swallowing is made more difficult or impossible.

Body Position

It is important to determine where and how a handicapped client should sit during mealtimes. The following conditions should be met:

I. Positioning is as symmetrical as possible with the handicapped client's head in the midline, and arms and legs controlled and toward the center of the body.

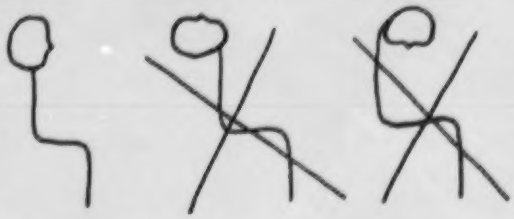
Reason: Symmetrical positioning assists in inhibiting the expression of primitive reflexes which allow only reflexive movements rather than voluntary, controlled movements.

2. Positioning is as upright as possible with handicapped client's head sitting squarely on top of spine and hips bent at a 90° angle.

Reason: When a handicapped client reclines and food is put in his mouth, the food tends to slide to the back of the mouth and slide down the throat, possibly causing him to aspirate (breath food into his lungs).

3. Positioning allows (or forces) head to be in correct front-to-back alignment with spine.

Reason: If the head is hung or pushed back, it is nearly impossible to close lips, chew food, or swallow properly. If the head is hung forward, it is very difficult to get the food in, to keep the food in his/her mouth, to mix it with saliva, and to swallow.



4. Positioning allows the client's feeder to give adequate external control to the oral mechanism.

Reason: Some clients are not able to control their own oral mechanisms, so it is the feeder's responsibility to provide external control.

5. Positioning provides stability and support of arms and legs with feet resting solidly on foot supports or on the floor with knees and ankles bent at a 90° angle (or as close as the client's deformities will allow) and the arms resting or restrained in a still position.

Reason: If the feet and arms have a solid base, the client will not have to be concerned with controlling excess movement in the legs and can concentrate instead on controlling the mouth in eating properly.

Some possible suggestions:

- a. In a beanbag chair
- b. In a "regular" chair that is adapted to enforce the positions mentioned above
- c. In a feeder's lap, if the client is small enough to be controlled as described above.

PART III: Normal Eating

It is important to examine the way children and adults normally eat. By the time children are three, they have generally mastered all the skills of eating that adults have. For many handicapped clients, we strive to encourage them to eat in a normal fashion, as adults do. The following are descriptions of normal eating of various types of food.

Eating From a Spoon

In eating food from a spoon, the following sequence occurs:

1. Mouth opens, with tongue resting on the floor of the mouth
2. Spoon is put in the mouth
3. Mouth and lips close on the spoon
4. Spoon is removed from the mouth as closed lips remove food from spoon
5. Tongue transfers food to one or both sides to be chewed
6. Food is chewed; tongue is constantly repositioning the food so that is can be effectively chewed
7. When it is felt that the food is chopped enough by the teeth, the food is transferred to the middle of the tongue in preparation for swallowing
8. Swallow occurs with lips closing, tip of tongue going up to ridge behind upper teeth; middle and back of tongue following in a wavelike backward motion
9. Swallow is repeated if residual food is detected in the mouth

Eating Cookies or Crackers

In eating cookies or crackers, the following sequence occurs:

1. Mouth opens with tongue resting on the floor of the mouth
2. Cracker is rested on lower teeth
3. Upper and lower teeth are brought together, biting off piece of cracker which lands on the tongue just behind the lower teeth
4. Tongue transfers food to one or both sides to be chewed
5. Food is chewed; tongue is constantly repositioning the food so that it can be effectively chewed
6. When it is felt that the food is chewed enough by the teeth the food is transferred to the middle of the tongue in preparation for swallowing
7. Swallow occurs with the lips closing, tip of tongue going up to ridge behind upper teeth; middle and back of tongue following in a wavelike backward motion

Drinking Liquid from a Cup

In drinking from a cup, the following sequence occurs:

1. Mouth opens with tongue resting on the floor of the mouth
2. Rim of cup is rested on lower lip
3. Tongue is positioned with tip down behind lower teeth, middle of tongue forms a seal against middle of hard palate
4. Cup is tilted so that the liquid meets tongue in the mouth

5. Liquid is sucked into the mouth by the tongue's downward movement which creates suction
6. Cup is removed when enough liquid is felt in the mouth
7. Lips close as cup is removed
8. Swallow occurs with lips closing, tip of tongue going up to ridge behind upper teeth, middle and back of tongue following in a wavelike backward movement

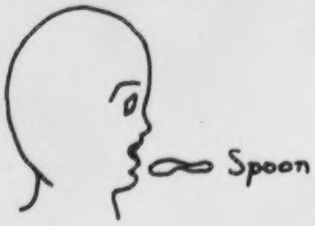
PART IV: Adaptive Feeding Techniques

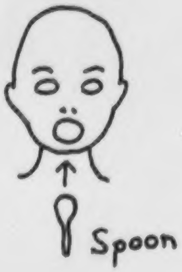
Because of oral sensorimotor problems, many handicapped clients are unable to follow the previously mentioned sequences in eating and drinking. Some of the feeding techniques used by feeders actually discourage the development of these normal sequences. The following adaptive feeding techniques should be used to encourage the handicapped client to develop behaviors listed in the normal feeding sequences.

Proper Presentation of Food

Uses: Many of the handicapped client's bodies "get stuck" in reflex positions, especially when their heads are turned to the side or tipped too far backward or forward.

Description: Handicapped clients should have food presented when their heads are positioned facing directly forward, even if you have to assist them in doing so. Also, food should be presented from straight ahead and coming from below eye level.



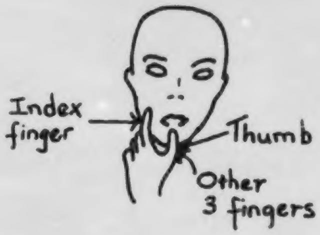


Jaw Control

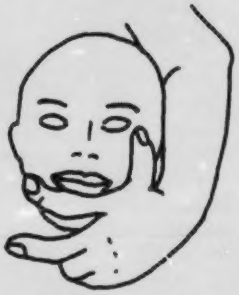
Uses: Jaw control is generally used when it is desirable to have the jaws and/or the lips closed or in closer proximity. Having the jaws closer also makes a smaller area in which the tongue moves and can facilitate better tongue action. Jaw control is useful when:

1. A client has jaw thrust and cannot purposefully close his jaws

2. A client doesn't have a jaw thrust, but opens his mouth too far as he attempts to suck food or liquid from a utensil
3. A client's most common action is tongue thrust. With jaw control, he cannot push it out as far if you are keeping his jaw shut



Description: Jaw control can be given either from the front or from the side. From the front, positioning is done as pictured on the right. Thumb is flat against the chin, just under the lower lip. Thumb can assist in both opening and closing the jaw. Index finger is extended along the jaw line, with the tip of the finger just below the temple. Index finger is used to stabilize the hand against the face. Third, fourth, and fifth fingers are bent horizontally across the width of the underside of the jaw. These fingers give the upward thrust to close the jaw.



From the side, jaw control is done as pictured on the left. Thumb is along the jaw line reaching up toward the temple. Thumb is used to stabilize the hand against the face. Index finger extends horizontally across the front of the chin and can assist in opening and closing the jaw and lower lip. Middle finger extends horizontally across the underside of the jaw and can assist in closing the jaw. Fourth and fifth fingers are curled gently and do not take part in the opening and closing.

CAUTIONS:
1. Giving too much pressure with any of the fingers can be painful to the client.
2. Giving jaw control when the client doesn't need it is wasted effort and may prevent him from making progress.
3. Giving jaw control can put the head out of alignment with the body, unless there is a firm, properly positioned support behind the head.

Jaw control can also be helpful if a client begins to choke during a meal. If he begins to cough and sputter, gently lean him forward or to the side so that excess food can be drained from the mouth. Then, assist him by giving him jaw control so that he can better remove remaining food by swallowing correctly. NEVER place a client who is coughing on his back.

CAUTION: When moving the client forward or to the side, do it very slowly. A sudden movement will cause him to take a quick breath of air which can lead to aspiration of the food or fluid in his mouth. This can be very dangerous.

Downward Pressure on the Tongue

When downward pressure on the tongue is necessary, it is best to use a tongue depressor rather than a spoon as an eating utensil. The rounded bowl of the spoon makes it very difficult to push down, and the sharp metal edge of the spoon makes it uncomfortable, even painful.

Uses: This downward pressure is generally used to help direct the tongue to accomplish a less abnormal movement and/or a more advanced or sophisticated movement. Downward pressure on the tongue is useful when:

1. A client "bunches up" his tongue or thrusts it out when you put food in his mouth
2. A client tongue thrusts in trying to move the food to the back of his mouth to swallow
3. A client tongue thrusts in trying to swallow the food

Description: Scoop the food with the tongue depressor just as you would with a spoon. When the client opens his mouth, or is assisted with jaw control in opening his mouth, the tongue depressor with the food on it is placed on the front 1/3 of the tongue. The pressure is then directed downward, with a slight backward (into the mouth) push, then removed.

PART V: Assistance in Self-Feeding

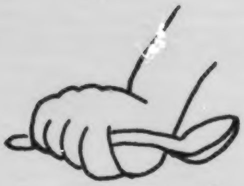
Clients who feed themselves or are learning to feed themselves must be maintained in a normal sitting position so that they have as much control of their arms, legs, and head as possible. Be sure that the client's chair is placed properly at the table so that the table edge is touching the front of the client's body. The table should be positioned at the height of the client's elbow.

CAUTION: Before beginning a self-feeding program with a client, be sure to check with the Speech Pathologist or Occupational Therapist to be certain that he is ready to begin self-feeding in terms of overall oral control. This is VERY important.

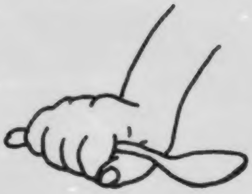
Assistance in self-feeding is useful when:

1. The client has difficulty in maintaining a firm grasp on the spoon handle without his wrist bending down or his thumb getting stuck under his fingers
2. The client cannot correctly scoop the food onto the spoon
3. The client has trouble getting the spoon directly into or out of his mouth
4. The client has difficulty getting the cup to his mouth without spilling liquid

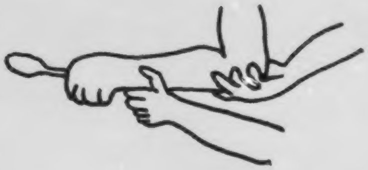
Description: If the client has better control with one arm and hand, ALWAYS let him use his better hand for self-feeding. However, his more affected arm must be positioned properly to better assist him in an overall proper body position. His arm should be extended forward on the tabletop with the palm of his hand placed downward.



If the client grasps the spoon with his thumb caught under his fingers (as shown on the left), have him open his hand. You may have to assist him in opening his hand by grasping his hand below the base of the thumb and gently rotating the thumb outward. Help him to grasp the spoon correctly with his fingers curled downward over the spoon handle and his thumb curved upward from under the spoon handle, resting on the outside of his fingers (as shown on the right). If the client cannot maintain this grasp, place the fingers of your same hand gently over his.



If the client tends to bend his hand downward from the wrist, or has difficulty scooping or directing the food to his mouth, help him by assisting his direction, grasping him at the wrist joint. Use your fingers and thumb to move the wrist slightly up, and your palm to direct the movements of his hand. If further directive help is necessary, use your other hand under his elbow (as shown on the right).



Remember to give the client ONLY as much assistance as he needs. If you give him too much assistance, you are denying him the opportunity to increase his skills in self-feeding.

HINT: If the client is having difficulty in self-feeding, check with the Speech Pathologist or the Occupational Therapist to see if adaptive feeding equipment may be helpful.

These are the most commonly used adaptive feeding techniques. They should be used under the conditions and guidelines suggested above. If you feel that you have used the techniques appropriately and consistently for three days, and no positive effects are noted, get in touch with the Speech Pathologist or Occupational Therapist by writing in the Consultant Communication Book.

Available as loan-copy for duplicating from:

Inservice Training Coordinator
Arizona Department of Health Services
Bureau of Child Development
200 N. Curry Rd.
Tempe, AZ
244-9471, Ext. 244.

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APPENDIX D

SPECIAL CONCERNS: TOILET TRAINING

Part 1: INTRODUCTION

Toilet training has not been considered a traditional area for public school education; with the entry of severely and profoundly handicapped students into the school, however, helping these students develop such self-care skills becomes a critical curriculum area. Most children develop toileting skills spontaneously or with minimal intervention, but severely and profoundly handicapped students need careful and systematic training. The approach must begin with a careful assessment of capabilities and needs, and, through the Individualized Education Program (IEP), formulation of goals and programming to meet those goals. Recent research indicates that with proper intervention and coordinated training, these citizens can be much more independent and can possibly even function in a nonsheltered environment.

Pertinent Questions

Has an inservice workshop been held for teachers and aides in the management of toileting, diapering, hygiene?

Who will plan the workshop; who will conduct the training?

What equipment is needed for self-care on the part of the students?

What equipment is needed for diapering, sanitary needs?

Have other sources of funding been investigated to help pay for these expenses?

Will supplies be disposable; will laundry service be needed?

Who will be responsible for purchase of disposable supplies?

What provisions are made for keeping records of children's toileting, sanitation?

How will daily communication with the home be accomplished?

What does the IEP say about the child's needs?

General Toilet Training Considerations[1]

Procedures

1. Procedures will, of course, take individual differences into account, and they will vary accordingly.

2. A standard reference for toilet training is: Toilet Training the Mentally Retarded (Foxx and Azrin). It has been stated that these programs are too time consuming; however, as the child is progressively toilet trained (becomes more independent), less and less time is required of the teacher. Programs for acquisition (learning) are usually more time consuming than programs for maintenance (retention). It should be recognized that different children entering the public schools will be at different points in the acquisition and maintenance process.

---

[1] Administrators Resource Manual for the Deinstitutionalization of Children and Youth, 1979.

3. Some curricula also contain toilet training programs.

Coordination between school and home environments

1. It is suggested that a single toilet training program, which contains school and home components, be constructed. The procedures for implementing the program should specify the exact actions of the teachers and home staff relative to the specific child. In this manner, the mechanism for coordination is the IEP conference, along with specific professional responsibilities (i.e., program writing). It is, therefore, important that representatives from the school and home program staff be present at the IEP conference.

2. Additional considerations are:

   a. An adequate conceptual and procedural understanding of the methods to be employed should be ensured; e.g., role-playing.
   b. Joint evaluations of procedural effectiveness should occur, along with joint decision-making regarding any change in the methods employed.
   c. Data should be collected daily in both home and school environments, and should be shared via communication books.

Diapering

See inservice training packet, "Diapering and Perineal Care."

Laundry service

1. The home has the responsibility for laundering clothing and diapers.

2. The home should be encouraged to send sufficient clothing for needed changes during the day, along with an ample supply of diapers (if the program specifies that diapers are to be used).

3. Soiled or wet clothing and diapers should be returned in a plastic bag each afternoon/evening with the child.

Equipment

1. Foxx and Azrin's book describes some equipment used in toilet training programs, and it should be consulted for details.

2. Kurt Mahoney, Tempe, is developing a device for daytime toilet training (The Potty Pager), and it should be available in the near future.

3. Also, consult Robert Schwitzgebel's chapter, "Behavioral Technology," in the Handbook of Behavior Modification and Behavior Therapy.

Sanitation and odor

1. Preventive action is critical. Some programs specify frequent pants checks of children, thus, sanitation can be ensured and odor minimized by needed clothes changes which should accompany pants checks.

2. Soiled or wet clothing and diapers should be placed in plastic bags.

3. Spray disinfectant-deodorants are available commercially.

Recordkeeping

Recordkeeping is an integral part of any program, and appropriate measurements should be devised by the interdisciplinary team for purposes of program evaluation (see Foxx and Azrin for sample data systems).

Diapering and Perineal Care[2]

After reading this packet, you should be able to discuss the topics listed below. You will learn best if you carefully read the objectives and remember them as you read the text. Review them before you meet with the instructor. For this last review, remember that you have learned the necessary information if you can answer questions about the objectives listed below. If you have any questions, ask the instructor before you take the written examination.

The following is a list of questions you should be able to answer in your own words upon completion:

1. When should diapers be changed?

2. Where are soiled diapers placed?

3. Where do you place clothing that becomes soiled?

4. What position should the client be placed in to change his diaper?

---

[2] Diapering and Perineal Care is an inservice training packet developed by the Bureau of Child Development, Arizona Department of Health Services.

5. How should diaper pins be placed? Why?
6. What should you do immediately before pinning the client's diaper?
7. Why shouldn't you pin over a bony area?
8. What type of client requires a forward diaper?
9. How is a forward diaper helpful to the client?
10. How should a forward diaper be pinned?
11. What type of client requires a backward diaper?
12. How is a backward diaper helpful to the client?
13. How should a backward diaper be pinned?
14. What type of client requires a security diaper?
15. How is a security diaper pinned?
16. How should the female client's genitalia be washed?
17. How and when should you mark a female client's menstrual flow?
18. How should you clean an uncircumcised male?
19. How should the B.M. chart be marked?
20. What observations should you report to nursing?

Diapering and Perineal Care

Objectives

Diapering and perineal care are important to the client for good health and hygiene. Diapering can be done in a variety of methods. It is important to know these methods of diapering so that you can diaper a client in the method that will be most therapeutic for him.

PART I: Diapering

Clients should be checked often for wet or soiled diapers, and changed whenever necessary. Check and change clients before meals, after meals, before dressing in the morning, before nap and bedtime, before and after programming sessions, as needed during the night, and any other times necessary.

Diapers are disposed of in the white laundry bags with other linen (i.e., washcloths, towels, etc.). If the client's personal clothing becomes soiled or wet, rinse them out in the toilet if necessary, and place them in the client's personal laundry bag (plastic).

When changing a client's diapers, it is extremely important to place his body in a relaxed position. This will help decrease the possibility of injury to the client. The client's legs should be bent at the hips and knees so that he cannot suddenly stiffen or arch his body. Maintain this position while you follow the diapering procedure:

1. Remove diaper pins and IMMEDIATELY close them. Place them out of the client's reach.

CAUTION: DO NOT put diaper pins in your mouth.

2. Clean the diaper area (buttocks and genitalia) with clear warm water. If the client has had a B.M., use "Peri-wash" with a warm washcloth. Be sure to wipe away from genital area.

3. Be sure to dry the client thoroughly to prevent the skin from drying and chapping.

4. Fold the diaper in the prescribed method being certain that the soft "textured" side is against the client.

5. Carefully, but snuggly, pin the diaper on the client. The pins should always be perpendicular to the client's spine (straight

across with the head pointing to the outside of the client's body). This will decrease the possibility of the pin opening accidentally as well as the possibility of injury to the client.

CAUTION: BEFORE pinning the diaper, place your fingers between the diaper and the client to prevent sticking the client with a pin. This rule is to be followed AT ALL TIMES.

HINT: If the pin does not slide easily through the diaper material, place the pin in a bar of soap. DO NOT run the pin through your hair, as this is very unsanitary.

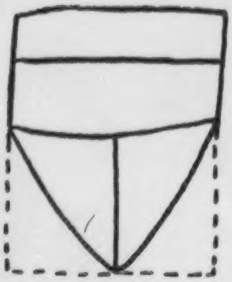
CAUTION: NEVER pin over a bony area. This can cause pressure points.

6. Check to make sure all pins are accounted for. If one is misplaced, do NOT leave the client until it is found.

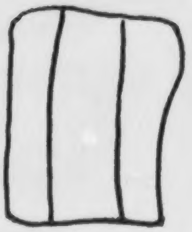
Each client has a prescribed diapering technique. At CDC, these techniques are listed in each team area. If you are unsure of the techniques with individual clients, always check to be sure you are using the correct one. These techniques were prescribed according to individual client needs, and must be used consistently to be the most therapeutic.

FORWARD DIAPER

Loose or floppy clients require a "forward diaper" to assist in bringing their thighs closer together.



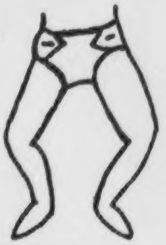
1. Fold the diaper to the appropriate size to fit the client with one end slightly narrower than the other. For smaller clients, a large diaper may be folded as shown on the left. An extra diaper may be folded into thirds and used for extra absorption, as shown on the right.



2. Place the folded diaper under the client, the wider end at his back.

3. Pull the diaper up between the client's legs snuggly.

4. Pin the back corners of the diaper over the front corners (as shown on right).



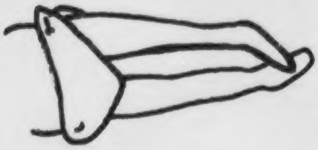
BACKWARD DIAPER

Stiff clients require a "backward diaper" to assist in pulling their legs apart.

1. Fold the diaper to the appropriate size to fit the client, with one end slightly narrower than the other.

2. Place the folded diaper under the client, the narrower end at his back.

3. Grasp the client's knees above the knee joint and slowly bend his hips and knees up as far as they will go. At the same time, slowly and gently spread his thighs apart. Maintain this position. If necessary, lean against the client's legs with your abdomen--very gently.



4. Pull the diaper up between the client's legs snugly, pulling his legs apart.

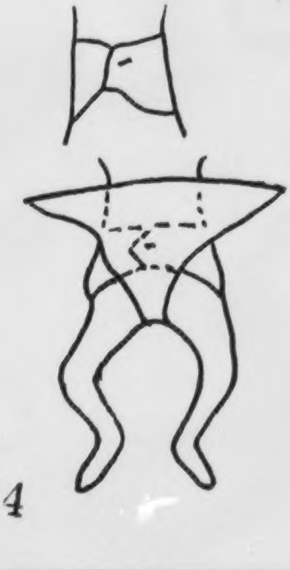
5. Pin the front corners of the diaper over the back corners (as shown on the left).

SECURITY DIAPER

Clients who play with their feces or have trouble keeping a diaper from slipping off require a security diaper.

1. Place an unfolded diaper under the client.

2. Fold a second diaper into thirds and place this inside the first diaper for better absorption.

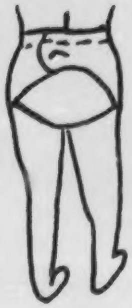


3. Pin the back corners of the diaper in front at the client's waist, as shown on the right.

4. Fold the outside of the front of the diaper inward under the client's legs to form a triangle.

5. Pull the diaper with the pad up between the client's legs snugly.

6. Open folds and grasp one front corner in each hand. Gently turn the client over on his stomach.



7. Pull the diaper snuggly around the client's legs, as shown on the right.

8. Gather the diaper around the client's waist and pin in the back as shown. Do NOT pin all the way through the pad.

CAUTION: Do NOT pin directly over the spine. Gather the diaper and pin slightly to the left or the right of the spine.

PART II: Perineal Care

Perineal care must be given at least once a day and after each bowel movement.

Female

1. Using a warm, soapy washcloth, clean genitalia gently but thoroughly.
2. Separate the vulva and carefully wash from front to back with a cotton ball. Do this only one time and throw the cotton ball away immediately. Repeat if necessary.
3. Rinse well.
4. Dry thoroughly to prevent chapping.

Female (during menstrual cycle)

1. Place the sanitary napkin with the blue strip away from the skin.
2. Soiled sanitary napkins should be wrapped in paper and discarded in the waste receptacle. Do NOT flush down toilet.
3. Mark each day the client is having a menstrual flow with a red star on the BM sheet.

Male (circumcised)

1. Using a warm, soapy washcloth, clean genitalia gently but thoroughly.
2. Rinse well.
3. Dry thoroughly to prevent chapping.

Male (uncircumcised)

1. Gently pull back the foreskin and wash with a warm, soapy washcloth.
2. Rinse well.
3. Dry thoroughly to prevent chapping.
4. Apply a thin coat of vaseline to the head of the penis and pull the foreskin back into place.

General Rules for Perineal Care

1. Use a soapy washcloth and/or "Peri-wash" only during bath time and after a B.M. Clear water will be adequate for other times and will help prevent dry skin.
2. Mark each day of a female client's menstrual period with a red star on the B.M. chart.
3. Mark each B.M. on the chart with a description of size and type for each client. (See B.M. code in team areas.)
4. Report all unusual observations to the team leader and team nurse immediately (i.e. rash, discharge, etc.).

Campbell, P. H. Daily living skills, in Haring, N. G., ed., Developing effective individualized education programs for severely handicapped children and youth. Columbus: Special Press, 724 Roosevelt, Columbus, Ohio 43209, 1977, $11.45 postpaid.

Foxx, R., and Azrin, A. Toilet training the mentally ill. Champaign, Illinois: Research Press, 1973.

Johnson, V. M., and Werner, R. A. A step-by-step learning guide for retarded infants and children. Syracuse, New York: Syracuse University Press, 1975.

Schwitzgebel, R. Behavioral technology, in Leitenberg, H., ed., Handbook of behavior modification and behavior therapy. Englewood Cliffs, New Jersey: Prentice-Hall, 1976.

APPENDIX E

SPECIAL CONCERNS: TRANSPORTATION

Part 1: INTRODUCTION

Planning transportation for moderately or severely handicapped students requires an individualized approach based on the unique needs of each student. Close communication must be maintained between the home or the group home and the school to assure that students will be ready for the bus and that someone will be at home to receive the students at the end of the day. Specialized equipment, trained drivers and trained aides to accompany the students will be needed. Planning must take into consideration the physical endurance limitations of some of these students, and assure that the students do not expend more time than is absolutely necessary on traveling to and from school. The transportation needs should be listed under related services on the child's individualized education program.

Questions

EQUIPMENT

How will students be transported?

What types of vehicles are available?

Will new vehicles be needed?

Method of obtaining?

What special equipment will be needed, e.g., wheelchair lifts, car seats, seat belts, harnesses, prone position carriers, etc.?

Can some of the students ride regular buses?

Can cooperative arrangements be made with other districts to share costs/use of special equipment?

Are loading, unloading areas adequate, safe, comfortable for students and staff?

PERSONNEL

What ratio is necessary for children:staff on the bus?

What staff training is necessary?

Who will function as aides on the bus?

What training is necessary for dealing with medical or discipline problems on the bus?

Does training include proper management of behavior problems? How does management on the bus relate to the child's IEP?

Who will develop training programs?

Who will provide/receive training?

Who is responsible on the bus?

Who is responsible for getting students on/off bus at school, at home?

Who is responsible at the bus stop?

How shall competencies of personnel be evaluated? How often?

Who will develop and coordinate routes with need/time/aides?

Do you have a job description for bus personnel?

Have funding sources for training been investigated?

GUIDELINES[1]

If you have adequate transportation, you will not need to consider the following. If not, steps suggested can be used to provide for safe and reliable transportation of the handicapped child.

1. Determine the population distribution.

2. Determine which students are in foster homes or residential placements and identify their transportation needs:

    a. for weekend transportation to home;
    b. for vacation transportation to home;
    c. for transportation to educational facility.

3. Determine which students cannot ride a regular school bus and their location:

    a. physically handicapped students confined to wheelchairs;
    b. students who exhibit extreme behavior problems, etc.

4. Develop bus routes in consideration of where physically handicapped students live.

    a. schedule wheelchair-lift buses for wheelchair students;
    b. select other students in the same area to complete the bus load.

5. Consider the following in making bus routes:

    a. time student leaves home and returns;
    b. amount of time student is on the bus;
    c. time bus arrives at school.

6. Determine where there are supervision needs:

    a. a minimum of one supervisor other than the driver on the bus;
    b. number of supervisors would depend on number of children, severity of handicaps and number of behavioral problems (two or three supervisors on a large bus is recommended).

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[1] S. B. Harrison and M. Johnson, Establishing Services for the Severely Handicapped in Public Schools. Salt Lake City: Southwest Regional Resource Center, University of Utah, 1975.

7. City bus lines

   a. consider city bus route in relation to where handicapped students live;
   b. arrange for payment of fare if a city bus is to be used (some bus lines do not charge fares for the handicapped);
   c. arrange for advocate or big brother to assist student in riding bus.

8. Some districts or service areas will not have a large enough handicapped population for a school. Consider:

   a. transportation to a regional center for the handicapped;
   b. transportation to a neighboring district or service center;
   c. contract with other district for transportation to its special school.

Inservice Training for Bus Drivers and Aides[2]

Time Period:	One 6-hour day per month for all new personnel
Equipment needed:	84 passenger bus, minibus, wheelchair, carrying seat, etc.

OUTLINE

1. Role as Driver and Aide

   Rules, team member, relationship with parents, teaching social skills, handling, attitude, patience and tolerance, etc.

2. Identification of all types of handicaps

3. Limitations of some children

   Mobility, communications, medical problems, etc.

4. Putting limits on children

   Dependency, inconsistency, assuming, etc.

5. Orientation to specialized equipment

   Shoulder harnesses, straps, belts, headrests, wheelchairs, lifts, etc.

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[2] This outline comes from an extensive aide-training curriculum from the Tucson Unified School District, P. O. Box 4040, Tucson, Arizona 85717.

6. Training on emergency procedures

   Seizures, choking, coma, etc.

7. Films

   "How To Lift"
   "Heimlich Maneuver"
   "Epilepsy"

8. Demonstration on proper lifting and handling of children and equipment

9. Behavior Modification

   Demonstration on the bus for typical behavior problems

Part 3: SELECTED BIBLIOGRAPHY

Borton, L. The one room school bus, Teaching exceptional children. Reston, Virginia: Council for Exceptional Children, Summer 1975.

Equipment distributors:
Auto Safety House
Phoenix, Arizona

SAMPLE

TRANSPORTATION SUMMARY[1]

Components	Numbers							Supervision				
	Capacity		Availability					Teacher	Aide	Parent	Misc.	
	10-20	21-60	M	T	W	T	F					
1. District school buses												
Wheelchair lift												
Regular												
2. Special school buses												
Wheelchair lift												
Regular												
3. Contract												Contractor
Wheelchair lift												
Regular												

Check space applicable on the following:

4. Public transportation

Other_____ Taxi_____ City bus line_____

5. Private transportation Yes_____ No_____

Car pools_____ Individual cars_____

6. Itinerant transportation Yes_____ No_____

Type:____

____

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[1] S. B. Harrison and M. Johnson, Establishing Services for the Severely Handicapped in Public Schools. Salt Lake City: Southwest Regional Resource Center, University of Utah, 1975.

APPENDIX F

TEACHER AIDE TRAINING

Part 1: Teacher Aide Training[1]

Training is a critical component in the quality and success of a program involving paraprofessionals and volunteers. To have a viable support system the necessary money and energy must be committed to recruitment, retention, and inservice training.

Description

The training program is designed to introduce the teacher aide to the types of handicapping conditions and to the teacher aide's functional role and attitude in assisting the teacher and pupil in the school environment.

Objectives

A. To introduce the aide to educational programs and facilities available to exceptional children.
B. To assist the aide in discovering his/her own personal responses to exceptional children.
C. To encourage development of resourcefulness, poise, and self-confidence as a teacher aide.
D. To familiarize the aide with school and career advancement opportunities.

What Is my Role as an Aide?

The teacher aide will assist the teacher in meeting the academic and physical needs of all children including the educationally and physically handicapped, and will help maintain proper classroom atmosphere.

Personal Qualifications

1. Tolerance and understanding of all children.
2. Initiative, so as to take over when needed without direction.
3. Creativity, for positive input into the program.
4. Adaptability, in all new situations and programs.
5. Good judgment, in decision-making situations.
6. Confidentiality, with all information about children and families.
7. Dependability, with regular attendance and punctuality.
8. Courtesy and tact with all other personnel.
9. Good health and appearance.

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[1] All information in Appendix F is from "In-Service Overview Training Program," by Vera Yager, aide trainer, Adaptive Education, Tucson Unified School District. Revised November 1977.

Teacher Assistance

Classroom

1. Arrange according to teacher's plan.
2. Assist in preparation, care and use of instructional materials and equipment.
3. Assist in maintaining good housekeeping standards.
4. Follow instructions under the leadership of the teacher.
5. Be alert in assisting to maintain desirable behavior standards.
6. Assist in detecting any behavioral, health or physical deviations which warrant the attention of the teacher.
7. Assume supervisory role during the teacher's temporary absence.
8. May assist the teacher by checking pupil's written assignments.
9. Operate and take care of standard audio-visual equipment.
10. Perform related duties as assigned.

Non-Classroom

1. Assist in the supervision of lunch room, playground and restrooms.
2. Carry out orders of therapists regarding care and management.
3. Accompany teacher on extracurricular activities.
4. Aid children in games and proper use of playground equipment.
5. Assist with clerical duties such as preparing instructional material, mimeographing, dittoing, typing, etc.
6. Assist children to and from bus.
7. Perform related duties as assigned.

Pupil Assistance

1. Assist with group and individual activities.
2. Supervise children moving from place to place in a safe, orderly manner.
3. Assist children with personal care and sanitary needs.
4. Aid children in feeding themselves during snack or lunch time.
5. Assist handicapped children in walking, using wheelchairs and using special equipment.
6. Aid children in using audio-visual equipment.
7. Assist children by following Individualized Education Program under supervision of the teacher.
8. Assist children under the supervision of teacher with instructional program.
9. Perform related duties as assigned.

ADDED DUTIES OF AIDES IN THE PHYSICALLY AND MULTIPLY HANDICAPPED PROGRAM

1. Assist in removing children's coats and hats.
2. Take attendance and lunch money.

3. Assist students with using bathroom facilities at appropriate times:
    a. helping student on and off stool
    b. helping students to wipe
    c. diapering when appropriate
    d. maintaining a schedule for toilet training when designated.
4. Assist students by lifting or transferring them from one position to another while maintaining appropriate safety, body alignment and body mechanics.
5. Carry-out reinforcement procedures directed by teacher.
6. Assist students in swimming program.
7. Prepare and distribute snacks when appropriate.
8. Practice appropriate hand-washing technique.
9. Observe clean and dirty area technique.
10. Assist students in transportation from one classroom to another:
    a. pushing a wheelchair
    b. accompanying a student with a walker or on crutches.
11. Follow safety procedures at all times.
12. Remove braces or other supportive gear when directed by teacher.
13. Use proper body mechanics when moving students and equipment.
14. Assist children during their lunch:
    a. getting trays in cafeteria line
    b. opening milk cartons
    c. cutting up food or opening packages
    d. spoon feeding if appropriate with designated technique from team
    e. helping hold cup and/or straw
    f. washing hands and faces
    g. being aware of individual allergies.
15. Perform related duties as assigned.

DUTIES OF HEALTH CLERK IN THE MULTIPLY HANDICAPPED PROGRAM

Under the supervision of the school nurse, the health clerk will perform the following tasks, in the assigned classroom only:

1. Administer minor first-aid in the classroom.
2. Initiate emergency life-support procedures stat and notify nurse stat.
3. Refer all nuisance infections to the nurse, e.g., herpes simplex, lice, impetigo, ringworm, etc.
4. Maintain first-aid kit and adequate health supplies in the classroom.
5. Give medications as prescribed under nurse's supervision as indicated on Medication Permit.
6. Assist with immunization and TBC programs.
7. Assist with physical examinations.
8. Assist with vision and hearing screening.
9. Assist Dental Department in obtaining health records, etc. during visit.

10. Assist with heights and weights on all students twice a year.
11. Assist nurse and classroom personnel to appraise students on medications:
    a. being alert to physical/emotional responses
    b. referring changes in behavior to nurse.
12. Help to maintain sanitary, healthful, safe conditions within the school environment by observation and inspections.
13. Maintain a daily register and discuss typical signs and symptoms with the nurse.
14. Be cognizant of variation in the physical health status of pupils --both routine and special problems:
    a. updating and reviewing the health status (case conference) with nurse daily
    b. assisting in making and following-up referrals
    c. referring parents requesting medical advice to nurse/family doctor DO NOT OFFER MEDICAL ADVICE
    d. assisting in compiling and recording appropriate health history and health data
    e. providing daily health inspections of students in the classroom
    f. giving skin care and examining students, especially during toileting
    g. helping to maintain adequate nutrition
    h. implementing nursing care procedures as indicated and cross-trained by the nurse, e.g., tracheotomy care, catheterization, bladder credé, postural drainage, etc.
15. Maintain professional and ethical responsibilities regarding all social and health information.
16. Develop an understanding of the school system and evaluate contributions of the health and education program.
17. Keep own knowledge up to date through formal and informal education.
18. Perform related duties as assigned by the nurse and teacher.

WHEN AND HOW WILL THE AIDE BE EVALUATED?

Aides will be evaluated by the teachers they are working with four times yearly--October, December, February and April. The Director of Personnel and the Aide Trainer will review the completed evaluation reports in May. Aides judged as not being satisfactory will not be recommended for rehiring.

This policy protects the best interest of the children whom teacher aides are employed to serve.

SAMPLE

TEACHER AIDE EVALUATION

School Year 19__ - __

0 = Not applicable
1 = Excellent
2 = Very good
3 = Satisfactory
4 = Needs some improvement -- Explanation
5 = Needs much improvement -- Explanation

Teacher____________________

School____________________

Aide____________________

Date of Employment____________________

	Oct	Dec	Feb	Apr
I. RELATIONS WITH PERSONNEL Displays courtesy and tact to: 1. Volunteers				
2. Cross-age helpers				
3. Staff and co-workers				
4. Public				
II. PERSONAL QUALITIES 1. Tolerance and understanding of all children				
2. Displays good judgment in decision-making situations				
3. Displays initiative--does not have to be told specific jobs each time				
4. Exhibits creativity with positive input into program				

SAMPLE
(cont.)

	Oct	Dec	Feb	Apr
5. Displays adaptability in new situations				
6. Gives adequate notice of absences by reporting to office or teacher				
7. Serves as a model for children in appearance and grooming				
8. Dependable--regular attendance carries out and meets deadlines on work				
9. Punctual--arrives in room on time				
10. Establishes feeling of trust and open communication between teacher and aide				
III. RELATIONS WITH CHILDREN 1. Proven ability to tutor small groups and individual children				
2. Gives positive reinforcement in consistent manner				
3. Withholds positive or negative reinforcement when appropriate				
4. Displays fairness and impartiality to students				
5. Shows ability to work and use disciplinary controls without immediate supervisor				
6. Is consistent in following through with behavior plans and disciplinary controls				

	Oct	Dec	Feb	Apr
7. Shows concern in children: Notices moods, physical needs, health problems				
8. Aide is able to achieve positive response from child				
9. Is aware of child's achievement of work and tasks				
10. Identifies next step of task to be expected				
11. Provides appropriate choices, thus permitting child to think for himself				
12. Encourages and rewards children for appropriate behavior and performance, minimizing failure				
13. Uses concise and clear directions which are easily understood by the child				
IV. QUALITY AND QUANTITY OF WORK 1. Neat, accurate, legible written materials, orderly record keeping, storing supplies, filing materials, etc.				
2. Plans ahead on assignments or activities				
3. Shows self-evaluating techniques				
4. Considers volume of output and extent to which work schedules are met				
5. Carries out instructions or suggestions in method or techniques to be used with children				
6. Is able to take over class when teacher must leave room				

SAMPLE
(cont.)

	Oct	Dec	Feb	Apr
7. Can locate needed materials				
8. Efficiently operates equipment: ditto machines, film strips, projectors, etc.				
V. PROFESSIONAL ATTITUDE				
1. Keeps information about children and families confidential				
2. Displays positive and cooperative attitude				
3. Makes effort to attend P.T.A. or other extracurricular events at the teacher's suggestion				
4. Accepts criticisms or suggestions with a mature attitude				
5. Avoids criticisms of children, the teacher and the school except to proper person for positive change				
6. Shows an interest in self-improvement, e.g., takes courses to improve work				

APPENDIX G

SELF-EVALUATION CHECKLIST

Self-Evaluation Checklist

Have the following criteria been met?	Yes	No	NA	Section
1. Awareness of the individual behavior and learning characteristics of the students Comments:				1
2. Establishment of staffing patterns and related services Comments:				2
3. Exploration and identification of placement options for students to include staffing assignments Comments:				2
4. Consideration of inservice training and procedures for implementation Comments:				2
5. Selection of diagnostic instruments Comments:				3
6. Diagnostic/assessment conducted for each student Comments:				3
7. Recording of information secured from assessment data Comments:				3

Have the following criteria been met?	Yes	No	NA	Section
8. Utilization of assessment information for program planning Comments:				4
9. IEP meeting conducted Comments:				4
10. Evaluation and selection of a curriculum that meets student goals and objectives Comments:				5
11. Development (as necessary) of curriculum to meet student goals and objectives Comments:				5
12. Modification (as necessary) of the selected curriculum to meet student goals and objectives Comments:				5
13. Identification of students' strengths and weaknesses, goals and objectives from IEP Comments:				6
14. Identification of the teaching strategies that would facilitate child change Comments:				6
15. Consideration of procedures for integration of the students into the regular education system Comments:				7

Have the following criteria been met?	Yes	No	NA	Section
16. Inservice training conducted for LRE integration Comments:				7
17. Coordination of procedure established for interaction between regular and special services Comments:				7
18. Consideration of architectural accessibility, classroom design, special problems and selection of adaptive equipment Comments:				8
19. Consideration of aesthetic concerns, decor, attractiveness Comments:				8
20. Establishment of communication between living environment and school Comments:				9
21. Establishment of parent involvement Comments:				9
22. Establishment of parent inservice Comments:				9
23. Securing and recording medical information Comments:				App. A

Have the following criteria been met?	Yes	No	NA	Section
24. Recording of emergency telephone numbers and appropriate addresses for individual students Comments:				App. A App. B
25. Working with paramedics Comments:				App. B
26. Establishment and practice of emergency exit procedures including staff training Comments:				App. B
27. Securing necessary permission forms for emergency procedures Comments:				App. B
28. Identification of feeding/drinking procedures and implementation of adaptive methods Comments:				App. C
29. Identification of suitable diets Comments:				App. C
30. Coordination with speech therapist for pre-speech training Comments:				App. C
31. Identification of correct toileting, hygiene procedures Comments:				App. D

Have the following criteria been met?	Yes	No	NA	Section
32. Implementation of teaching self-care skills in toileting Comments:				App. D
33. Identification of transportation concerns and enactment of appropriate procedures Comments:				App. E
34. Proper utilization, evaluation of aides Comments:				App. F
35. Use of checklist Comments :				App. G